Toward Culturally Competent Care

A Toolbox for Teaching Communication Strategies

Center for the Health Professions

University of California, San Francisco

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Sunita Mutha, MD, FACP
Carol Allen, MA
Melissa Welch, MD, MPH

Center for the Health Professions
University of California, San Francisco

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PREFACE

Toward Culturally Competent Care is a curriculum designed to teach health care professionals the knowledge and skills needed to provide care to a diverse population. We view cultural competency as a tool to improve quality of care and to reduce disparities in utilization of procedures, health outcomes and quality of care across racial and ethnic populations.

Toward Culturally Competent Care reflects a decade of cumulative experience designing, facilitating and evaluating interdisciplinary workshops for health professionals. It builds on two prior curricula "Enhancing Awareness and Improving Cultural Competence in Health Care" (Welch, 1999) and "Culture and Communication in Health Care: A Curriculum for Teaching Culturally Appropriate Care to Health Professionals" (Ackerman, 2000).

This curriculum was developed under the auspices of the Network program, which is housed at the Center for the Health Professions at the University of California, San Francisco. The Network's mission is to bring together health care organizations and academic centers to develop and disseminate knowledge and resources to improve the quality of medical practice through education. This curriculum reflects one effort to help clinicians enhance or develop skills that improve their ability to effectively work in changing health care environments.

The mission of the Center for the Health Professions is to assist health care professionals, health professions schools, care delivery organizations, and public policy makers respond to the challenges of educating and managing a health care workforce capable of improving the health and well-being of people and their communities.

We gratefully acknowledge the important contributions of Sara Ackerman, MPH and Kenneth Wolf, PhD in shaping sections of this curriculum and providing suggestions for case studies. We are indebted to Indria Sylvester for her excellent administrative assistance in every phase of this work. This curriculum would not have been possible without funding from the California HealthCare Foundation.

We wish you success in your training endeavors.

Sunita Mutha, MD, FACP
Division of General Internal Medicine
Center for the Health Professions

Carol Allen, MA
Center for the Health Professions

Melissa Welch, MD, MPH
Division of General Internal Medicine/SFGH
Health Plan of San Mateo

University of California, San Francisco

TO THE TRAINER

Introduction

As we become a more diverse society, we must begin to value the many dimensions of our differences including race, gender, class, sexual preference and physical ability. In the health care setting, these differences often result in discrepancies in the care received and in health outcomes. More recently, issues of diversity in health care have come to be known by the term cultural competency. We use the term cultural competency to describe a set of skills, knowledge and attitudes that enhance a clinician's:

- understanding of and respect for patients' values, beliefs and expectations;
- awareness of one's own assumptions and value system, in addition to those of the U.S. medical system;
- ability to adapt care to be congruent with the patient's expectations and preferences.

Teaching Cultural Competency

Cultural competency in health care is an ideal. For trainers, the challenge to teaching cultural competency is two-fold. The first is to prepare clinicians who demonstrate an understanding of and respect for the values, beliefs and expectations of their patients. The second is to help clinicians apply new knowledge and skills to each patient encounter to achieve improved clinical outcomes.

Underlying what might be referred to as the practical and intellectual components of cultural competency training, however, is what we call the "heart work." By this we mean the process of identifying and questioning our biases and values and considering the world from different points of view. Heart work challenges us to consider racism, prejudice and bias and to address how effectively we interact with diverse groups within our organizations. Do we trust each other across race, gender and other dimensions of differences? Do we tolerate or intervene when prejudicial or stereotypical comments are made? Do we believe that valuing diversity means lowering our standards for quality employees? When training includes opportunities for learners to engage in such self-reflection, we are moving closer to cultural competency in health care.

Curriculum Rationale

This curriculum was developed and refined as a result of nearly a decade of combined experience training health care professionals in cultural competency skills. We recommend that trainers take a few minutes to review the introductory material in order to understand some of the rationale for the choice of curricular content as well as its organization.

This curriculum is best thought of as a toolbox of materials for teaching culturally competent skills to health professionals. The content and format focus on practical day-to-day encounters between clinicians and patients and the materials are organized to address attitudes, knowledge and skills that comprise culturally competent care. We have included an array of materials to allow trainers to choose components that meet the needs of their audience.

Our approach emphasizes experiential learning as a means of expanding awareness and developing new knowledge and skills. The curriculum includes information on specific cultural groups only when such information will help the learner understand and gain insight into the experience of being different. Our focus is on developing communication skills that will assist the clinician to elicit accurate information and provide appropriate care to his/her patients, regardless of their cultural background.

Organization of Curriculum

The curriculum is organized into eleven sections. Each section contains exercises that are didactic or experiential in nature and that include descriptions of purpose, learning objectives and teaching instructions. Also included are: information on time requirements, description of materials needed for implementing the exercise as well as all overheads and handouts. Trainers are encouraged to adapt this curriculum to reflect their own experiences and training environments.

The curriculum evolves in a step-wise fashion beginning with the learner's personal cultural beliefs and attitudes, extending to the patient/clinician interaction and concluding with the learner's work and organizational settings.

- Section I focuses on the individual learner and addresses 1) self-awareness regarding culture and ethnicity, 2) recognition of one's personal and professional cultures and 3) acknowledgement of the diversity of personal health beliefs. The goal of this section is to

highlight how the learner has developed his/her cultural beliefs and attitudes and to use this awareness as a means of gaining insight into the beliefs and attitudes of their patients.

- Section II establishes the foundation for developing communication skills by articulating a common language that learners can use during cultural competency training. Terms such as culture, ethnicity, traditional healers, cultural competency and, most difficult of all, race are discussed and the exercises provide an opportunity to establish and refine definitions for these terms.

- Section III describes the imperative for cultural competency in health care. This section contains the rationale for cultural competency work in relation to demographics and health disparities data. Current demographic information describes the changing profile of the U.S. population and is contrasted with the demographic profile of health care providers. The evidence for health care disparities is also outlined. Finally, federal mandates and federal standards for culturally competent care (CLAS Standards) are described.

- Sections IV through VII are devoted to enhancing awareness of the diverse perspectives that patients and clinicians bring to the health care encounter and to developing skills in delivering care that bridges cultural and linguistic differences. The exercises teach skills for conducting culturally appropriate interviews, understanding alternative health care practices and beliefs and working effectively with medical interpreters. Case studies and simulations are included to give the learner the opportunity to practice new skills in the patient-clinician encounter.

- Sections VIII and IX focus on the institutional setting. Recognizing that the work environment influences care, these sections help the clinician to address work-related issues that arise as a result of personal interactions with a diverse workforce and organizations. In Section VIII, the learner works through a series of exercises that focus on cultural differences in health care teams, conflict management and consensus building. Section IX reviews the role and responsibilities of the health care institution in assuring an environment that values cultural competency. Suggestions are presented for assessing and creating culturally and linguistically appropriate facilities and work environments that encompass all aspects of the institution from the boardroom to administration, the exam room to the community.

- Section X is intended to help the trainer develop evaluation tools that can demonstrate the effectiveness of training sessions and the impact of trainings. Trainers are urged to assess the needs of their audience prior to designing trainings. Trainers are guided on approaches to designing evaluations using structured questions based on specific learning objectives along with questions that capture other information such as changes in clinical practice, knowledge, awareness and skills and anticipated outcomes.

- Section XI includes a listing of all of the references and resources cited in the preceding sections.

The Continuum of Cultural Competency

Achieving cultural competency is an ongoing goal that holds the promise of improving the quality of care for all populations. We use three models of cultural competency to describe the continuum along which each of us will travel (see Section I). The Bennett and Cross models focus primarily on attitudinal change as the learner increases knowledge, awareness, and hopefully, appreciation of cultural differences. The critical element, however, is the application of knowledge, skills and awareness in the health care setting to provide quality care. The Campinha-Bacote model reminds us that culturally competent care involves clinicians skillfully engaging with patients and applying awareness, knowledge and skills in each clinical encounter. This curriculum is an effort to reach the goal of culturally competent care for all populations.

TRAINER ORIENTATION

Trainer Readiness

The success of a given training is highly dependent on the skills, experience and preparation of the trainer. This curriculum emphasizes a hands-on approach to developing skills for providing culturally competent care. In writing this curriculum, we have assumed that individuals who plan to teach the content have:

- experience in designing curricula and in teaching health professionals;
- familiarity with the content and concepts related to cultural competence; and
- experience in facilitation of group discussions and experiential learning.

The content in this curriculum may evoke emotional or highly charged reactions from participants. Trainers should feel confident in their ability to manage anger, denial and conflict in group settings. We recommend that trainers openly acknowledge that some topics can generate strong feelings among the group. In addition, the trainer must be clear about the biases, prejudices and values that s/he brings to the training and be prepared to have these challenged by learners.

In Preparation

Unless we know where learners are in their thinking and understanding of diversity issues, we will not know where we want to take them. We encourage trainers to assess these needs before designing a training program. This assessment can be used to assess prior cultural competency training, information about practice settings, patient populations of interest and other particular assistance the learner might want or be expecting. The needs assessment can be used to develop learning objectives and selection of appropriate topics and exercises for trainings. The assessment will also help guide the design of an appropriate evaluation to measure the effectiveness of the training.

In addition to the definition of cultural competency described earlier, trainers may want to consider an alternate definition of cultural and linguistic competency which is included in the National Standards for Culturally and Linguistically Appropriate Services in Health Care, or CLAS Standards. These standards are further described in Section III.

Strategies for Designing Effective Trainings

When planning a training session, it is important to proceed in a systematic manner. A logical sequence is to proceed from didactic to experiential exercises and from less threatening to more risky and challenging activities. We suggest that trainers avoid high-risk simulations at the beginning of their program. We recommend the following organization for trainings:

Inform	Use lectures and other didactic approaches.
Experience	Engage learners in exercises that demonstrate the point(s) made in didactic presentations.
Identify	Solicit learners' responses to what they experienced and felt.
Reflect	Ask learners to process what they experienced and link experience to ideas presented in didactic presentation and learning objectives.
Apply	Discuss how the concepts learned from the exercise can be applied to clinical settings and personal or professional experiences.

After completing an experiential exercise, such as a simulation, be sure to leave adequate time to debrief and to make the link between the activity and the learning objectives explicit. If time is an issue, we recommend limiting the duration of the experiential activity in order to allow adequate time for reflection.

For each training session, we recommend trainers consider the repertoire of teaching methods (lectures, case studies, critical incidents, simulations, and videos) available to them and choose methods based on appropriateness for the audience, setting and learning objectives.

The content in many of the exercises can elicit strong emotional reactions. We recommend that trainers begin their sessions by establishing group norms. This discussion helps to define rules for group behavior and establish an atmosphere conducive to effective learning.

Once norms are established, the trainer or participants can use them as a way of reminding each other of the "rules of behavior" that everyone has agreed upon for maintaining a supportive learning climate. The exercise "Establishing Group Norms," is included in this introduction as one example of a critical first step for trainers to take before embarking on their training program.

We assume that trainers will begin each session with an explanation of the objectives of the training and an agenda of what will be addressed in the training. We recommend that trainers define terms that will be used frequently, such as cultural competence, culture and race. This will assure that the group begins with a shared understanding and has an opportunity to discuss differences in opinion at the onset. The exercises in Section II provide a format for presentation and discussion of commonly used terms. If there are significant differences of opinion about definitions, it may be helpful to allow the group to change definitions to reflect the group consensus. It is the responsibility of the trainer, however, to correct misinformation and factual errors throughout the training.

The last step of each exercise is a reminder to the trainer to link the different aspects of the learning process for the learner. The transition should review the objectives of the exercise, the lessons learned, and the application to learners' work environments. Finally, the transition explains how the exercise is linked to subsequent training activities. By providing a context in which to understand the exercise, the trainer reinforces the learning process and integrates the information.

Orientation to the Curriculum

The curriculum is organized in eleven sections as described above. Each section, except the last, begins with an introduction that explains the content and learning objectives. Within each section are a number of exercises that are labeled alphabetically, indicating their sequence in the section. For example, the second exercise in Section II is labeled Exercise IIB: The Role of Culture in the Clinical Encounter. Each exercise includes the following content: the type of activity; time requirements, purpose and learning objectives, materials needed, and an outline for a suggested sequence for the facilitator. Handouts and overheads are included, when needed, and are labeled so that they are linked with the section and exercise. All references are included in Section XI.

TIME: 15 MINUTES — Exercise A: Establishing Group Norms

MATERIALS

Flipchart/markers

Type of Activity
Discussion

Purpose
To create a positive learning climate by establishing guidelines for group discussion that will help learners feel comfortable about participating in training activities.

Learning Objective
Participants will be able to articulate group norms agreed upon by consensus.

Steps

1. Explain what is meant by group norms. Give one or two examples of possible group norms, e.g., "Start and end on time," "Personal comments made during the training are kept confidential," "No side conversations."

2. Ask the group to suggest norms that will guide them during the training. Write them on the flipchart as they are mentioned.

3. Go through the list, asking for clarification if needed.

4. With the participation of the group, consolidate the norms into a list that everyone approves of.

5. Give the list the title "Group Norms" and tape it to the wall where it can be seen and referred to throughout the training.

6. Tell the group that the norms will be used throughout the training and that they can add or change ground rules as a group at any time. You may suggest other ground rules you feel may be helpful that haven't been stated, by saying "Other groups have found this group norm helpful. Does anyone want to add this to our list?"

7. Ask participants to discuss ways to ensure that the group norms are adhered to throughout the training. One possibility is to appoint a person to serve as the individual responsible for reminding participants to adhere to the norms for the session.

8. Transition to the next exercise.

SECTION I *Culture: Looking Within*

Introduction

The exercises and didactic material in Section I focus on increasing awareness of cultural differences at a personal level. Implicit in this section is the premise that everyone brings with them cultural beliefs and attitudes that influence interpersonal interactions. As learners are able to recognize the influence of their personal experiences and cultural backgrounds on their values and beliefs, they become more open to understanding the same process in others who present as being different from them.

We begin by demonstrating how we quickly make assumptions about people based on limited information. While we will always look for "shorthand" ways to draw conclusions in our encounters, we must recognize that we often will be wrong about these assumptions. In addition to drawing premature conclusions about an individual, we run the risk of missing critical characteristics of an individual unless we take the time to probe for additional information.

The section continues with an exploration of the developmental and cultural influences that have shaped personal values, beliefs and health practices. Often, health professionals hold health beliefs and traditions that are inconsistent with the biomedical model in which they were trained. Indeed, we might continue following family healing traditions, or complementary and alternative medical practices, whether or not they are helpful in curing illness, simply because they are familiar and provide comfort. Several cultural competency models are presented to help the learner understand the continuum of acquiring new awareness and skills. The section concludes with a discussion of the culture of medicine and how it influences health professionals' beliefs and practices.

Learning Objectives

At the conclusion of Section I the learner will be able to:

1. explain why appearances can often lead to incorrect assumptions about individuals;
2. describe some unique beliefs and practices that individuals have regarding health and healing traditions;
3. describe some of the influences that shaped their personal values and beliefs;
4. articulate the process of becoming aware of cultural differences and of developing skills to achieve cultural competency in health care;
5. describe the variety of cultural values and beliefs that influence individual behavior.

TIME: 20 MINUTES — Exercise IA: First Impressions

MATERIALS

Accessories such as cowboy hat, African headpiece, shawl, tie-dyed tee shirt.

Type of Activity
Discussion

Purpose
To demonstrate how easy it is to make incorrect assumptions based on limited information.

Learning Objective
Participants will be able to articulate how impressions of an individual based on appearances can be misleading.

Steps

1. In advance ask a staff member (or participant) to volunteer to model one of the accessories in front of the audience.

2. Ask the group to describe their first impressions of the person standing before them. Write down their responses.

3. When this list is complete, ask the volunteer whether each of the statements is accurate. (e.g., "She is an activist." "He's a hippie and smokes pot." "She's from the country and not very sophisticated.")

4. Ask the volunteer a series of questions to elicit the kind of information that describes his/her unique characteristics. Possible questions include:

   - Where were you born?
   - What are your hobbies?
   - What's the name of the last book you read?
   - Do you do any volunteer work?

5. Thank the volunteer and have her return to her seat. Ask the group what they learned from the model that was different from their first impressions.

6. Transition to the next exercise.

Exercise IB: Family Healing Traditions

TIME: 30 MINUTES

Type of Activity
Discussion

Purpose
To create an atmosphere where everyone's experiences are valued and to begin to look at cultural differences in healing practices.

Learning Objective
Participants will be able to articulate some differing health beliefs that they and others grew up with.

MATERIALS

Flipchart / markers

Handout IB.1: Family Healing Traditions

Steps

1. Distribute the handout. Ask participants to write down some of the health beliefs and practices that their families instilled in them.

2. Ask participants to pair up with someone in the group. Ask pairs to share responses to the questions on the handout.

3. Bring the group back together. Ask for volunteers to share their family health beliefs and traditions.

4. Ask the group if each of the practices actually helps with the illness. If it doesn't, ask them to describe reasons for continuing to use these practices. End by summarizing the variety of health beliefs among families of the participants and ask participants to consider how this understanding might help them in working with patients.

5. Transition to the next exercise.

HANDOUT IB.1

FAMILY HEALING TRADITIONS

1. **Describe a health belief practiced in your family.**

2. **Describe a home remedy that you use or that you learned from your family.**

Exercise IC: Personal Values and Beliefs — TIME: 60 MINUTES

Type of Activity
Lecture / Discussion

Purpose
To explore how cultural values and beliefs are shaped. By reflecting more deeply on their own assumptions and biases, participants will develop greater understanding and acceptance of beliefs that differ from their own.

Learning Objective
Participants will be able to define their own cultural values, beliefs and assumptions.

MATERIALS

- Paper and pens for participants
- Flipchart / markers
- Overhead IC.1: The Terry Cross Model
- Overhead IC.2: The Milton Bennett Model
- Overhead IC.3: Campinha-Bacote Model

Steps

1. Explain that culture is a framework that shapes and directs the way we behave and the way we interpret other people's behaviors. It gives us a set of rules for how to interact with others, how to express ourselves and how to deal with conflict. Culture influences the way we experience illness, and how we express illness, pain and our health care decisions.

   As we saw in Exercise IA, culture is not always visible. We are usually unaware of how culture influences our behavior and assume that our cultural rules are the norm. Cultural competence does not come naturally and it is human nature to be ethnocentric. Ethnocentrism occurs when we use our own cultural rules to compare ourselves with, or to judge, people who are different from us. The first step to becoming culturally competent, therefore, is to examine our own cultural norms and values.

2. Review Overheads IC.1 and 2 and explain that these models can serve as a framework to describe the cultural competency continuum. These models can be useful at a personal, workplace or institutional level. It might be helpful to refer back to these models at several points throughout the training.

3. Ask the participants to think about how they acquired their cultural beliefs and attitudes. What were the sources of their information? Give examples only if they are struggling. (Examples: parents/family, religion, where they grew up, health professions education/training, friends, travel) Write down each source of cultural learning on a flipchart.

4. Hand out paper and pens to the participants and ask them to write down examples of values, beliefs and rules that they learned from each of the sources. You may choose to focus on only a few sources. Ask them to also write down how these values and beliefs affect their work as clinicians.

5. Facilitate a discussion using some or all of the following questions (it may help to use personal examples to get the discussion going):

   - What were the most important influences that shaped your values and beliefs?
   - How have your values and beliefs changed over time?
   - What caused these changes?
   - How might values and beliefs from one source conflict with those from another?
   - How do you reconcile these differences?
   - How do your beliefs and values influence your work? How does your work influence your beliefs and values?
   - How does working in a diverse environment challenge your beliefs and values?
   - How can your understanding of the sources of your cultural learning help you in your job?

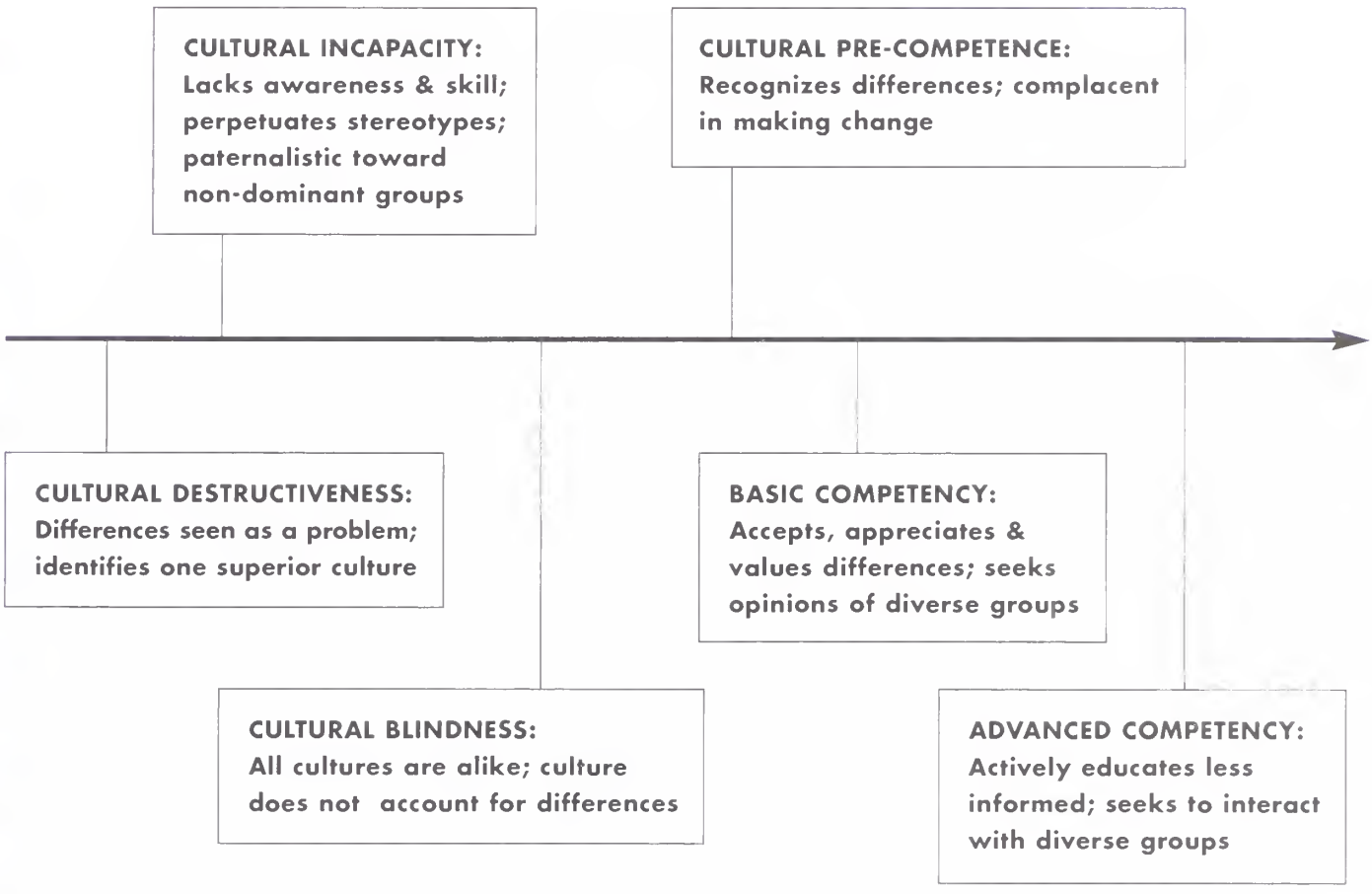
6. Use Overhead IC.3 to explain the long-range goal of training. Culturally competent health care results in the application of awareness, knowledge and skills to the clinical encounter. All are critical elements.

7. Summarize the discussion and transition to the next exercise.

OVERHEAD IC.1

CONTINUUM OF CULTURE COMPETENCY

Terry Cross Organizational Cultural Competency Model

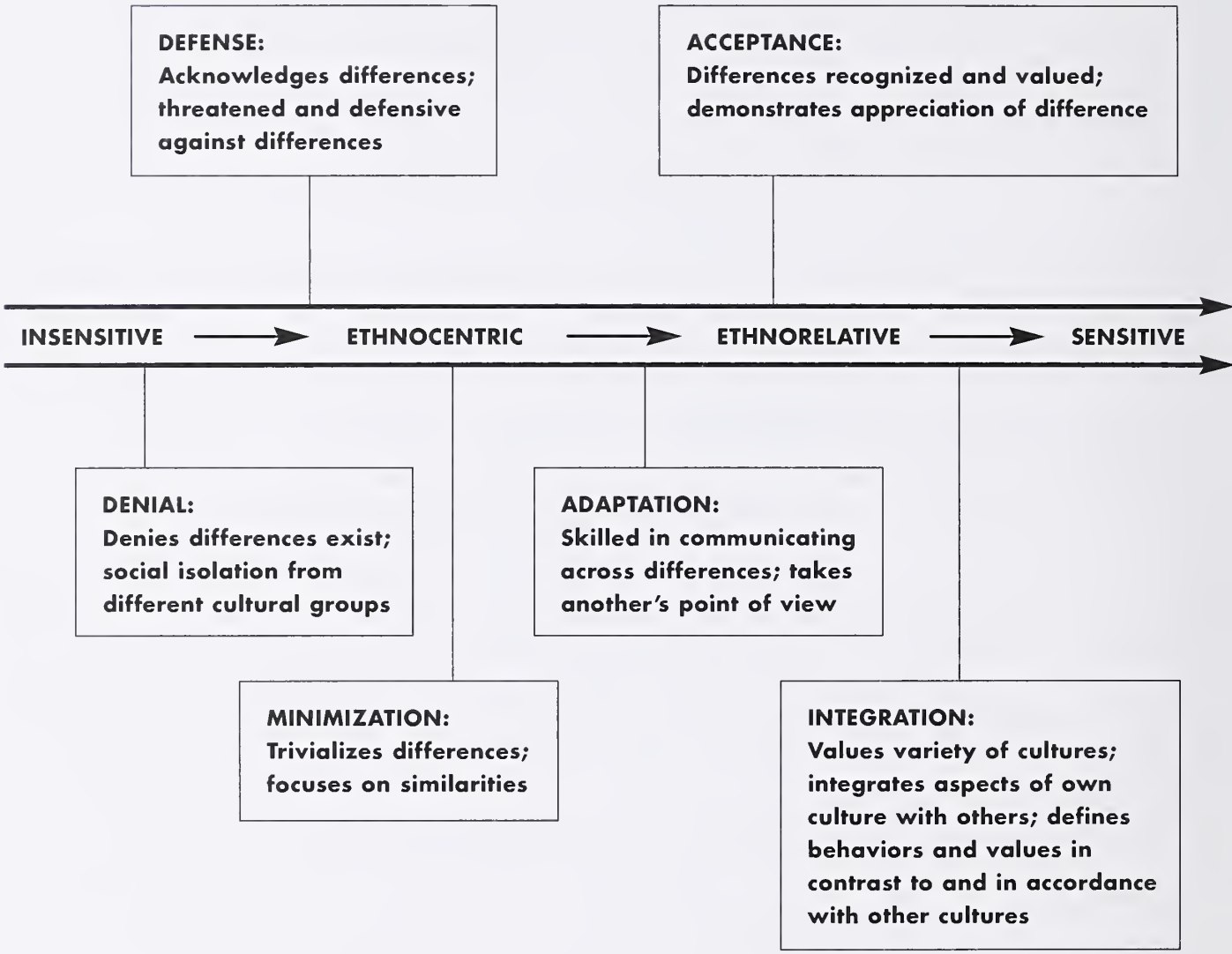


Adapted from Cross, 1989.

OVERHEAD IC.2

CONTINUUM OF CULTURE COMPETENCY

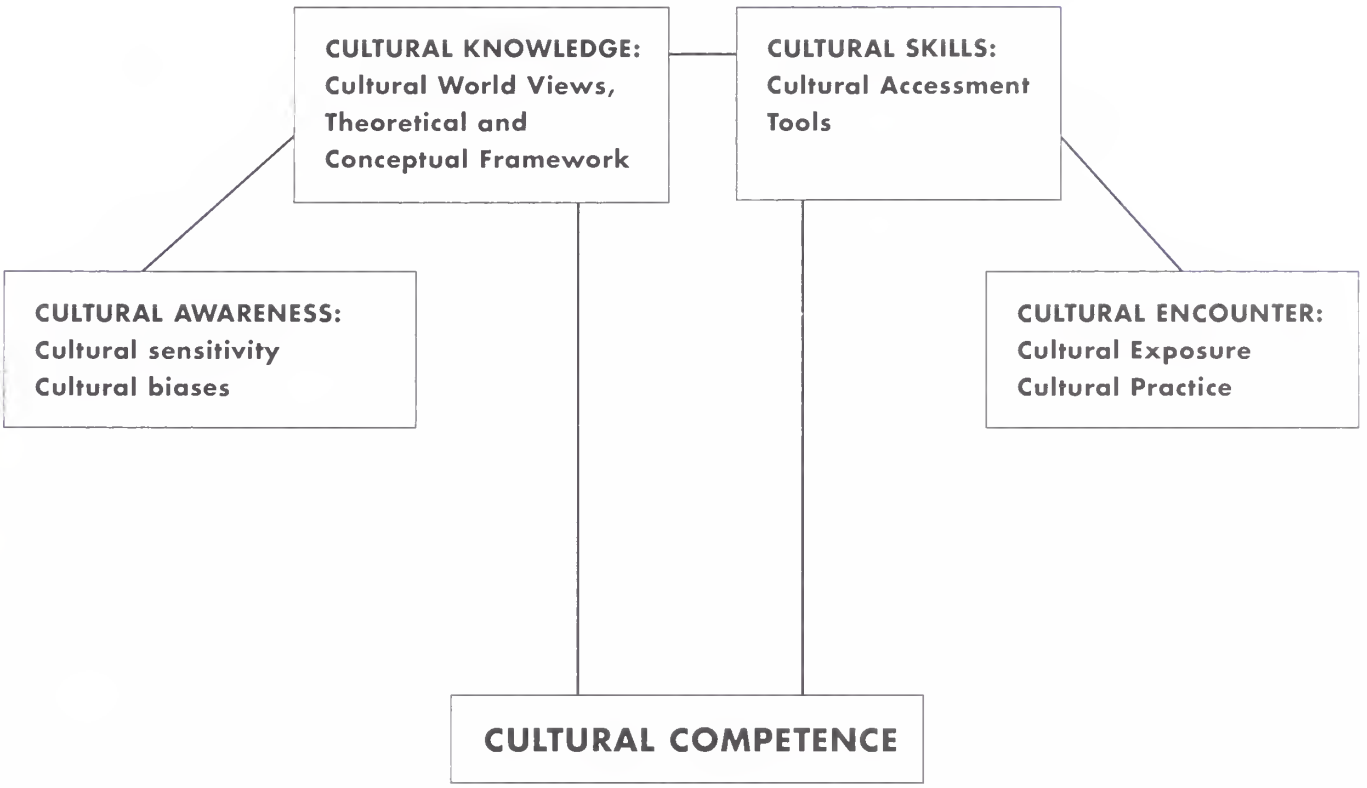
Milton Bennett Developmental Model of Intercultural Sensitivity



Adapted from Bennett, 1986.

OVERHEAD IC.3

CULTURALLY COMPETENT MODEL OF CARE
Campinha-Bacote



Adapted from Campinha-Bacote, 1998.

TIME: 30 MINUTES **Exercise ID: Personal Use of Complementary & Alternative Medicine**

MATERIALS

Handout ID.1: Personal Use of Complementary and Alternative Medicines

Flipchart / markers

Type of Activity
Discussion

Purpose
To explore the use of complementary and alternative medicine (CAM) among participants and to encourage dialogue about the reasons for such usage.

Objective
Participants will become aware that they, along with their patients, may turn to CAM practices, even in light of unclear efficacy.

Steps

1. Distribute the handout and allow participants 5 minutes to complete.

2. Ask the group the following questions for each type of the CAM practice. Record answers on a flip chart.

   - With a show of hands - how many of you use or have used each type of CAM listed?
   - What are some of the reasons you chose these practices?
   - How did you learn about the practice?
   - How effective is/was it?
   - What do you know of the evidence that supports the efficacy of this CAM practice?
   - Would you recommend it to your patients?
   - How do you react when your patient informs you about a CAM practice s/he has chosen to use?

3. Remind participants that most people, whether health professionals or not, use a variety of practices that are considered "self care." Identify and discuss themes about the reasons that these practices are chosen.

4. Transition to the next exercise.

PERSONAL USE OF COMPLEMENTARY AND ALTERNATIVE MEDICINE

Review the following list of complementary or alternative practices. Check the box for each practice that you've heard of and for each practice that you've used. Fill in reason(s) that you chose to use the practice and how it helped you.

Type of CAM	Have heard of it	Have used it	Why I chose it	How it helped
Alternative medical systems (e.g., acupuncture, ayurveda, homeopathy, naturopathy, qi gong)	☐	☐		
Mind-body interventions (e.g., meditation, hypnosis, dance/music/art therapy, prayer, mental healing)	☐	☐		
Biologically-based therapies (e.g., herbal therapies, Atkins/Ornish/Pritikin diets, vitamins)	☐	☐		
Manipulative and body-based methods (e.g., osteopathic manipulations, chiropractic, massage therapy)	☐	☐		
Energy therapies (e.g., qi gong, Reiki, therapeutic touch, magnets)	☐	☐		

Adapted from http://nccam.nih.gov/fcp/classify/

TIME: 30 MINUTES

Exercise IE: The Culture of Medicine

MATERIALS

Overhead IE.1: The Culture of Medicare

Handout IE.2: Acculturation to the Culture of Medicine

Flipchart / markers

Type of Activity
Discussion

Purpose
To help participants begin to see western biomedicine in the U.S. as a culture in itself. It will help them understand and question the biases in medical culture and why patients may not feel comfortable in a medical setting.

Learning Objective
Participants will be able to chart their own process of acculturation into the medical culture and will be able to list some of the values, beliefs and assumptions of medical cultures.

Steps

1. Introduce this exercise by explaining that even though biomedicine is thought to be driven more by science than by culture, research has shown that culture plays a powerful role in the way a disease is treated. If participants are interested in reading more about this, you may want to provide them with a list of suggested readings. Also mention that subsequent exercises will include more in-depth discussions about different health belief systems. (See Section IV.)

2. Present Overhead IE.1. Ask the group to consider factors that influence the way the health care system is organized. Is it organized around the needs of the patient or the needs of the system and its practitioners? Ask for examples of such dissonance from the participants' personal experience.

3. Ask participants to think about their health care training. Ask volunteers to share aspects of their training that were most memorable in learning the culture of medicine.

4. Distribute Handout IE.2 and organize participants into small groups. Instruct the groups to continue the discussion by reviewing the questions on the handout. Allow 10 minutes.

5. Reconvene the large group and ask groups to share their responses to the questions.

6. Transition to the next exercise.

OVERHEAD IE.1

THE CULTURE OF MEDICINE

Timing of Care

- Patient is awakened at 6:00am for medications.
- Office appointments are only available between 8:30 – 5pm.

Location of Facilities

- Patient is taken to one location in the hospital for a chest x-ray and then a separate location for a CT scan.
- The facility for having blood tests taken is one block away from the office.

Institutional Policy

- All patients are required to wear hospital gowns during their stay.
- Visiting hours are limited to coincide with nursing shifts.

Depersonalization

- The room size does not accommodate having the patient's family attend the visit.
- Hospital room layout and curtains limit patient privacy.

HANDOUT IE.2

ACCULTURATION TO THE CULTURE OF MEDICINE

- **What was one of the most difficult adjustments you had to make upon entering professional school/training?**

- **What did you have to give up in order to become a health care provider?**

- **How is health care influenced by and/or different from mainstream U.S. culture?**

- **What has been your personal experience as a patient seeking health care? Have you experienced a "disconnect" between your values and beliefs and those of the health care system?**

- **What is it like for a patient with a different cultural orientation to encounter the medical setting?**

SECTION II *Establishing a Common Language for Cultural Competency*

Introduction

There is both a lack of knowledge and confusion about terminology frequently used in cultural competency training. This section clarifies terms and provides the foundation of understanding upon which the learner will develop new communication skills in subsequent exercises.

The definitions of key terms are ones that we have used in training. You may modify them to reflect personal preferences or the needs of the group. We recommend that you review these definitions and ask participants to comment on them or suggest changes so that there is a common starting point. Exercise IIA provides an outline for discussion. These terms can generate charged reactions and participants may have personal preferences for phrasing and language choice. We encourage you to give the group the opportunity to express their opinions and concerns at the outset and to correct any misinformation and factual errors.

Definitions

- **Culture** is a set of learned and shared beliefs and values that are applied to social interactions and to the interpretation of experiences. Individuals often will embrace more than one culture at the same time.

- **Race** is a biological concept, having social meaning.

- **Ethnicity** is self-defined and relates to one's identity with a group that shares a history, religion, nationality and/or cultural patterns.

- **Complementary and Alternative Medicine (CAM)** practices are health care efforts initiated by the individual that are not presently considered an integral part of conventional medicine. Implicit in this definition is the acknowledgement that as CAM practices are proven safe and effective they may become adopted into mainstream health practice.

- **Cultural competency** is a set of skills, knowledge and attitudes, which enhance a clinician's 1) understanding of and respect for patients' values, beliefs and expectations; 2) awareness of one's own assumptions and value system in addition to those of the U.S. medical system; and 3) ability to adapt care to be congruent with the patient's expectations and preference. (For an alternative definition see the CLAS Standards definition in Section III.)

- **Traditional healers** provide health care to their community by using 1) plant resources, animal and/or mineral substances; 2) practices based on social, cultural and religious tenets; and 3) knowledge, attitudes and beliefs that are prevalent in the community regarding physical, mental and social well-being and the causes of disease and disability.

Learning Objectives

At the conclusion of Section II the learner will be able to:

1. articulate a working definition of the following terms: culture, race, ethnicity, CAM, cultural competency, traditional healers;
2. distinguish between the concepts of race and ethnicity;
3. distinguish between CAM and traditional healers;
4. describe the dimensions of culture that influence the clinician-patient relationship.

Exercise IIA: Defining Common Terms

TIME: 15 minutes (each)

Type of Activity
Discussion

Purpose
To give participants an opportunity to become familiar with definitions of key terms that will be used in subsequent exercises and to demonstrate the difficulty in arriving at consensus about value-laden language.

Learning Objective
Participants will be able to articulate a working definition for the following terms: culture, race, ethnicity, complementary and alternative medicine, cultural competency and traditional healers.

In Preparation
Prior to beginning this exercise write out your definition of each term you plan to discuss on separate sheets. The introduction to this section includes all definitions.

In preparation for the discussion of complementary and alternative medicine (CAM), it might be useful to refer back to Exercise ID in Section I in which participants review their own use of CAM practices.

To expand your discussion of traditional healers and traditional practices you may want to use the overheads in Section IV (Exercise IVC).

MATERIALS

Flipchart / markers

Overhead IIA.1: Definition of CAM

Steps

1. Present your definition of each term, one at a time. Ask the group for their suggestions for change to the definitions you have provided.

2. Use Overhead IIA.1 to present examples of CAM practices. Remind participants that patients who choose CAM approaches are seeking ways to improve their health and well-being and to relieve symptoms associated with illness or the side effects of conventional treatments.

3. Write down the final definitions on new sheets and post in the room for the remainder of the training. Refer back to these definitions when there is confusion or disagreement. Remind participants that at some point the group might want to refine its definitions.

4. Transition to the next exercise.

OVERHEAD IIA.1

DEFINITION OF CAM: Complementary and Alternative Medicine

Complementary and alternative medicine practices (CAM) are best described as those not presently considered an integral part of conventional medicine. Implicit in this definition is the acknowledgement that as CAM practices are proven safe and effective they may become adopted into mainstream health practice.

Examples of CAM practices are:

- **Alternative medical systems**
  - acupuncture
  - ayurveda
  - homeopathy
  - naturopathy
  - qi gong
- **Mind-body interventions**
  - meditation
  - hypnosis
  - dance/music/art therapy
  - prayer
  - mental healing
- **Biologically-based therapies**
  - herbal therapies
  - Atkins/Ornish/Pritikin diets
  - vitamins
- **Manipulative and body-based methods**
  - osteopathic manipulations
  - chiropractic
  - massage therapy
- **Energy therapies**
  - qi gong,
  - reiki
  - therapeutic touch
  - magnets

NCCAAM Major Domains, 2000

Exercise IIB: The Role of Culture in the Clinical Encounter — TIME: 60 MINUTES

Type of Activity
Discussion

Purpose
To apply the definition of "culture" to a clinician-patient encounter and to explore dimensions of culture that may not be immediately apparent.

Learning Objectives
Participants will be able to:
1. describe how culture influences the clinical encounter;
2. identify several dimensions of culture.

In Preparation
Create three patient scenarios to present to the group. For each scenario pick a clinical setting (hospital room, outpatient surgery practice, etc.) and choose a volunteer (or staff member) to be the "mock" patient. Choose volunteers with different physical characteristics (age, ethnicity, etc.).

MATERIALS

Overhead IIB.1: Dimensions of Culture

Flipchart / markers

Steps

1. Introduce the scenario and identify the mock patient: "You have been asked to see this patient for the first time for sudden onset of shortness of breath. While waiting for the patient's records, you decide to go into the exam room to begin your assessment of Ms/Mr _____."

2. Ask the group: "Upon entering the exam room what are your first impressions?" Record their responses on a flip chart. (The focus of this question is to emphasize how we make assumptions based on appearances.)

3. With each response, ask the speaker, "How did you arrive at this impression? Is it based on visible cues? Is it based on an assumption?"

4. Next to each impression record a "V" for a visible impression and an "A" for an assumed impression.

5. Using a separate sheet, ask the group what they will need to know about the patient apart from medical history to provide appropriate care. (e.g., language spoken, health or religious beliefs, DNR status, etc.)

6. Emphasize that what we know about an individual on a first meeting is only what we see, whereas the majority of a person's qualities or characteristics are not apparent. Given that the most important aspects are not visible, it is important that we spend time and effort learning how to test assumptions and stereotypes and elicit information to achieve a deeper understanding of people we provide care for.

7. Present Overhead IIB.1. Explain that these dimensions have a strong influence on the clinical encounter and that the more a clinician knows about these aspects of his/her patient's culture, the better care s/he will be able to provide. As you explain each dimension, give or elicit specific examples of how each one might influence the outcome of the scenario. If you choose to expand this discussion you can turn to Exercises VIA and VIB for a description of key elements that can influence the clinical encounter.

8. Transition to next exercise.

OVERHEAD IIB.1

DIMENSIONS OF CULTURE

Dimension	Questions to Consider
Health and Illness Beliefs	What paradigm is used to explain illness/healing?
Decision-making style	Does decision-making rest with the individual patient, the group/family or community peers?
Healing Traditions	What are the alternative/complementary approaches used for healing? What is the role of traditional healers (e.g., shamans)?
Locus of control	Is the individual responsible for his or her own destiny or is destiny predetermined?
Status/hierarchy	Is the status of head of household conferred by age, gender or kinship? What status is attributed to physicians and healers?
Privacy	Is privacy at the level of the individual or the family?
Communication	Is there a preferred mode of communication (e.g., spoken, written, sign)? Is there a preferred language (e.g., English, Spanish, etc.)? Is an interpreter needed? Is a cultural broker needed?
Socioeconomic status	Is social status in the community conferred based on family, vocation, wealth or education?
Immigrant status	Are the patient/family immigrants? How long have they been living in the U.S.? Are there acculturation and generational issues at play? Is immigrant status a potential legal concern?

SECTION III

The Imperative for Cultural Competency

Introduction

Section III uses demographic data and published literature to establish a rationale for cultural competency training. The 2000 U.S. Census reports demonstrate what many know intuitively — the profile of the U.S. population is changing dramatically. We recommend that you gather demographic information about your state and local region in order to individualize the information and demonstrate the compelling need for training at the local level. California and national data are presented in this section.

Included in the demographic information is a description of the language abilities and educational attainment levels of state and national populations. These data highlight the magnitude of the difficulty that individuals with limited English proficiency can have in being understood by their health care provider and in accessing appropriate care.

Data about the demographic profile of health professionals are included. These data suggest that it will be many years before health professionals reflect the population as a whole and underscore the need for training all health professionals to deliver culturally competent care.

We then focus on compelling data that demonstrate health disparities between and among ethnic and white populations. We offer several examples and encourage you to update references from relevant literature. The evidence for health disparities is one critical reason to consider cultural competency training as a tool for improving the quality of care that is delivered to all patients regardless of their ethnic or cultural background.

The section concludes with Federal responses to disparities in health care, with a focus on the 2001 Culturally and Linguistically Appropriate Services (CLAS) Standards.

You may present this section sequentially as it stands, or might want to select certain exercises and intersperse them throughout the training. We recommend you keep current with the U.S. Census information, which is continually being updated, and with the literature on health disparities.

Learning Objectives

At the conclusion of Section III the learner will be able to:

1. describe the local patient population in his/her health care setting;
2. explain how the U.S. population has changed between 1990 and 2000 and describe how these changes affect health care;
3. identify selected references that demonstrate evidence for health care disparities among ethnic populations;
4. describe the scope of the CLAS Standards and discuss their impact on the health care setting.

TIME: 60 MINUTES

Exercise IIIA: The Changing Demographic Profile

MATERIALS

Handout/Overhead IIIA.1Do You Know Your Patients?

Overhead IIIA.2: Changing Demographics: U.S.

Overhead IIIA.3: Changing Demographics: California

Overhead IIIA.4: Language Use and Educational Attainment

Overhead IIIA.5: Demographic Profile of California Health Professionals

Overhead IIIA.6: Minority enrollment in U.S. Medical Schools, 1990 and 2000

Type of Activity
Lecture/Discussion

Purpose
To provide a rationale for cultural competence training by illustrating the rapidly growing ethnic populations in the U.S. and California and the simultaneous lack of increase in minority health care professionals.

Learning Objectives
Participants will be able to:
1. describe the changing demographic profile of the U.S. and California (or their own state);
2. describe the demographic profiles of the patients and clinicians in their own practice settings.

In Preparation
This exercise contains demographic information about the general population as well as health professionals. You may want to divide the presentation in two and focus on Handout and Overheads IIIA.1–IIIA.4 for part one and then go on to Overheads IIIA.5 and 6 for part two.

For Handout/Overhead IIIA.1 we assume that participants are all from the same clinic, hospital, or other health setting. If this is the case, complete the overhead before the training with information specific to participants' facility. Before presenting the overhead, distribute a blank copy and ask participants to complete as much of it as they can. The goal here is to compare participants' knowledge of the racial/ethnic distribution of the patient population they serve to the actual racial/ethnic distribution. Then, follow steps 1–6 as outlined below.

If participants are from different locations, skip steps 1–3 and ask participants to form small groups with people who work in the same geographical area. Have them compare their answers and discuss their perceptions. Suggest that one person from each small group volunteer to find the correct information after the training and convey it to the other members of the group. Continue with steps 4–6 as outlined below.

For Overhead IIIA.4: For those who are conducting this training in a state other than California, please go to the U.S. Census website (see Section XI) for information on your state.

For Overhead IIIA.5: This information will need to be gathered for other states in advance of the training. The goal is to compare participants' knowledge of the racial/ethnic distribution of health care professionals to the racial/ethnic distribution in the general population. In addition, you may want to consider presenting data (Shulman, 1999 and Chen, 2001) about the possible physician role in differential use of cardiac catheterizations presented in Exercise IIIB.

Steps

1. Distribute Handout IIIA.1 and ask participants to take a few minutes to fill it out on their own (give them about 5 minutes.).

2. When they are finished, reveal the correct answers on Overhead IIIA.1. Ask participants how close their answers were to the actual numbers.

3. Present information on Overhead IIIA.2 and Overhead IIIA.3. Explain that since the year 2000, one third of all U.S. citizens are members of a "minority" group. California has the most diverse population of any state.

4. Discuss the increase in "minority" groups in the U.S. and the even greater increase in California. Use Overhead IIIA.4 to demonstrate the large number of non-native-English speakers and educational attainment of the U.S. population. Discuss how these data will affect the delivery of health care.

6. Present Overhead IIIA.5. Discuss the fact that while the minority population is increasing in California, the number of minority health care professionals is not. Use Overhead IIIA.6 to demonstrate the enrollment figures for minority groups in U.S. medical schools. Ask participants what might be the implications of this trend for patient care, considering that patients and physicians report feeling more comfortable in a medical interaction with someone they perceive as similar to themselves.

7. Transition to the next exercise.

HANDOUT IIIA.1 **OVERHEAD IIIA.1**

CHANGING DEMOGRAPHICS: Do You Know Your Patients?

Directions: Estimate the percentage of patients in each of the following categories in your facility.

ETHNICITY/NATIONALITY

___ African American	___ Latino	___ Filipino
___ Korean	___ Armenian	___ Chinese
___ East Indian	___ Japanese	___ Middle Eastern

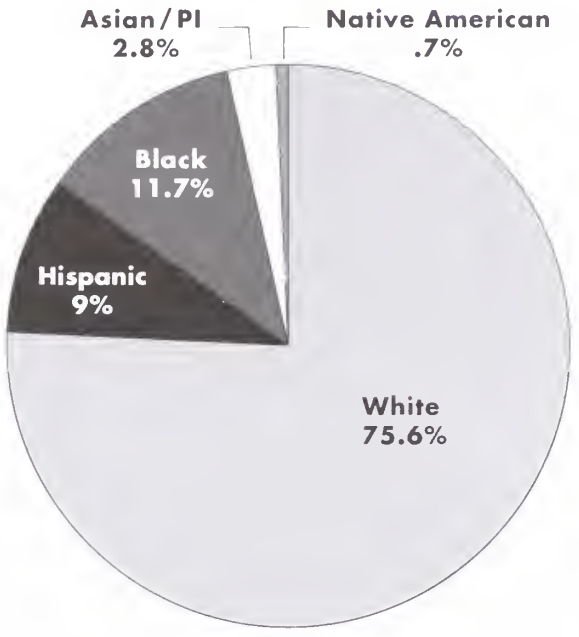
LANGUAGE

What percent of patients in your facility speak the following languages as their native language?

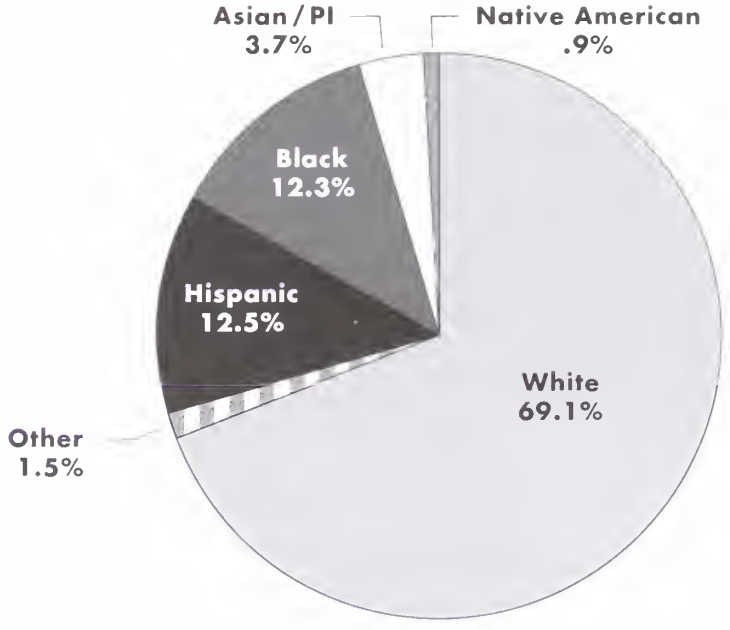
___ English	___ Spanish
___ Vietnamese	___ Cantonese
___ Tagalog	___ Other

OVERHEAD IIIA.2

CHANGING DEMOGRAPHICS IN THE U.S. (Percentage of Population)



1990

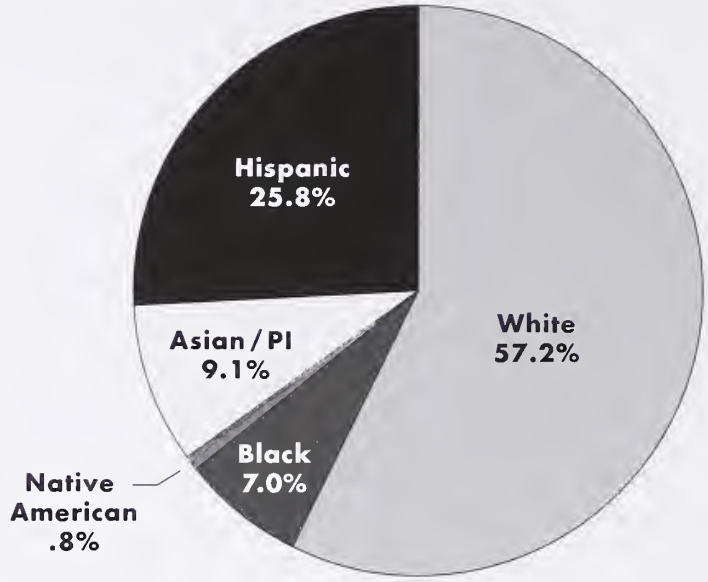


2000
(Race/Ethnicity categories differ from 1990 Census)

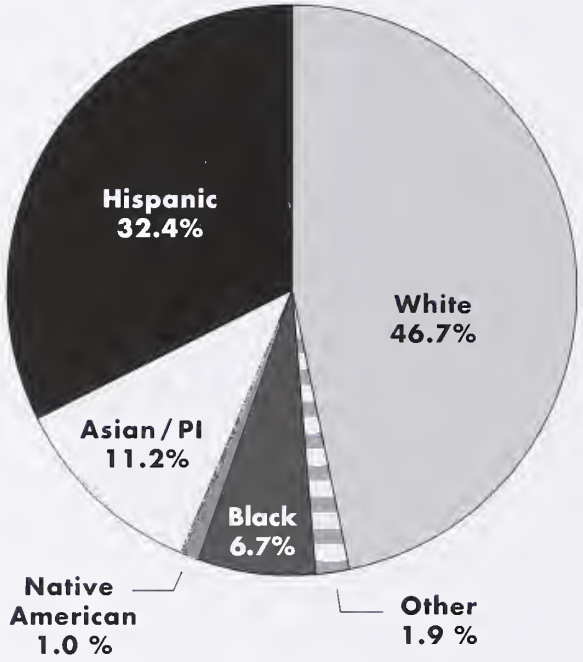
U.S. Census 2000.

OVERHEAD IIIA.3

CHANGING DEMOGRAPHICS IN CALIFORNIA (Percentage of Population)



1990



2000
(Race/Ethnicity categaries differ fram 1990 Census)

U.S. Census 2000.

OVERHEAD IIIA.4

LANGUAGE USE AND EDUCATIONAL ATTAINMENT

Educational Attainment of U.S. Population >18 Years

	All Races %	Asian/ Pacific Islander %	Hispanic %	White %	Black %
< 6th grade	3.3	5.5	18.3	3.2	3
7th to 11th grade	13.6	9.3	24.7	12.8	19.9
High school graduate	32.8	21.8	28.3	33	35
Bachelor's degree	15.7	26.4	6.3	16.1	10.1
Graduate degree	7.5	13.3	2.7	7.8	4.3

Adapted from U.S. Census Table 1: Educational Attainment of the Population 15 years and over, by Age, Sex, Race, and Hispanic Origin: March 2000.

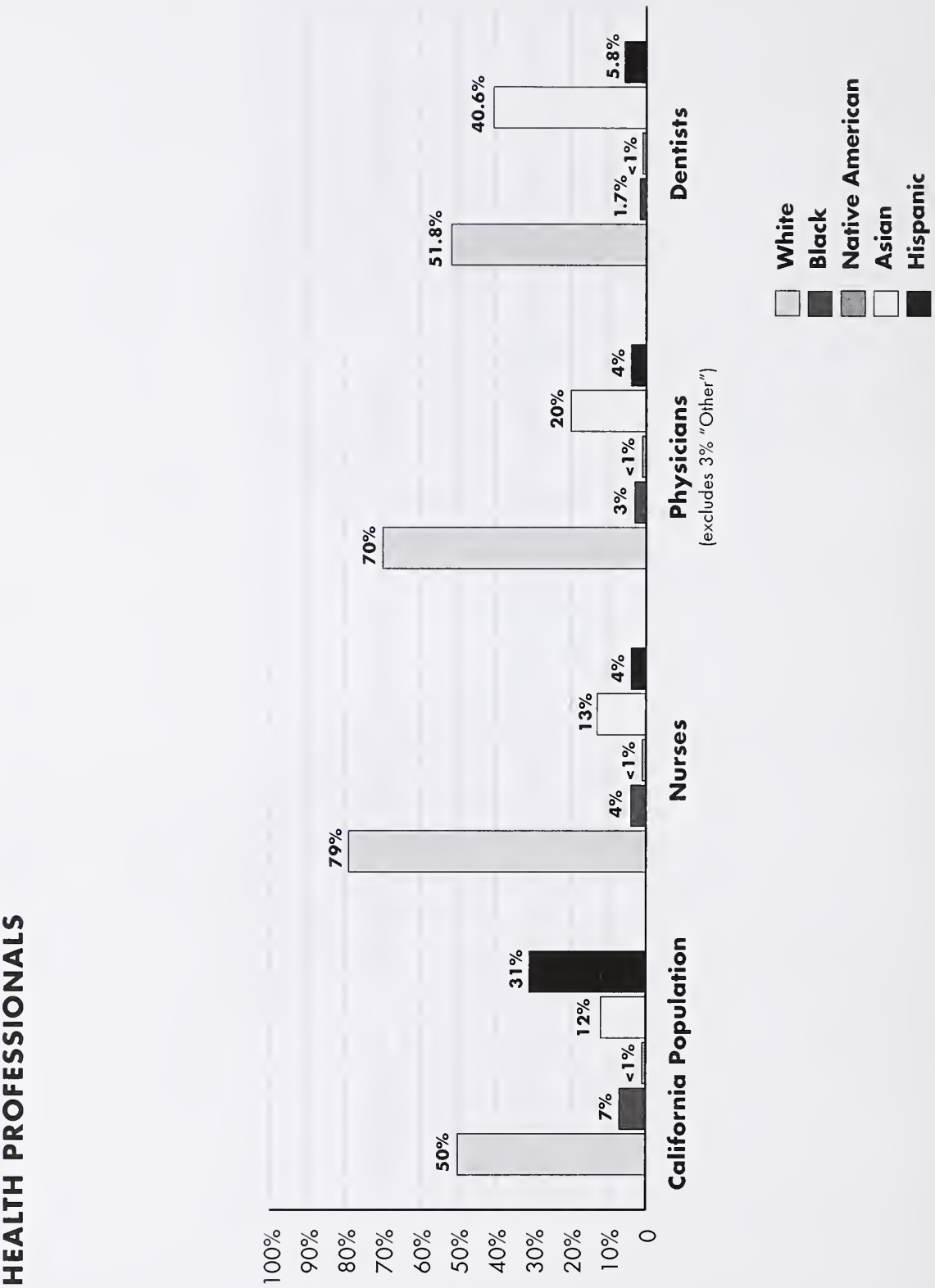
Language Use and English Ability, 1990 Census

			Speak Non-English Language at Home	
	Speak English only %	Speak Other language %	Speak English very well or well %	Speak English not well or not at all %
California	68.5	31.5	72	25
New York	76.7	23.3	79	21
Texas	74.6	25.4	79.5	20.5

Adapted from U.S. Census Table 1: Language Use and English Ability, Persons 5 Years and Over, by State: 1990 Census.

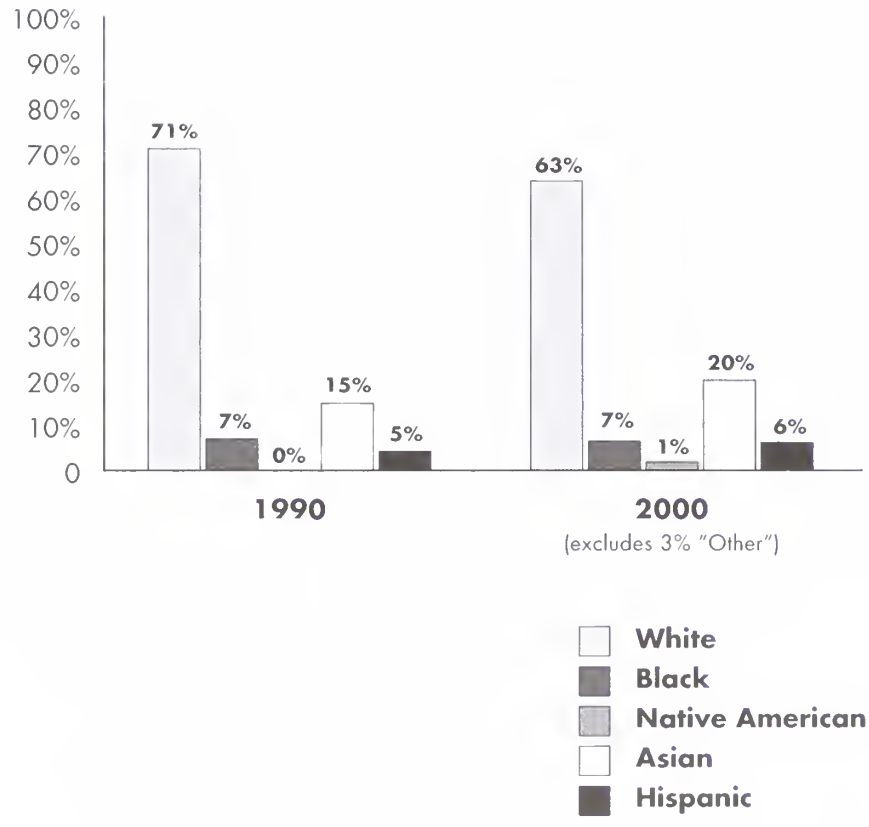
OVERHEAD IIIA.5

DEMOGRAPHIC PROFILE OF CALIFORNIA HEALTH PROFESSIONALS



Dower, C, 2001; Barnes, 1999; Mertz, EA, 2000.

ENROLLMENT BY RACE / ETHNICITY IN U.S. MEDICAL SCHOOLS, 1990 AND 2000



Dower, 2001

TIME: 60 MINUTES

Exercise IIIB: The Evidence for Health Disparities

MATERIALS

Overhead IIIB.1: Defining Health Disparities

Overhead IIIB.2: Leading Causes of Death in 1999 by Race and Ethnicity

Overhead IIIB.3: Healthy People 2010 Findings

Overhead IIIB.4: Ethnic Differences in Use of Analgesics in an Emergency Medical Center

Overhead IIIB.5: Role Of Clinicians in Health Disparities

Type of Activity

Lecture/Discussion

Purpose

To provide a rationale for cultural competence training by illustrating the disparities in access to care and health outcomes that have been linked to the racial/ethnic characteristics of patients.

Learning Objectives

Participants will be able to:

1. define what is meant by the term "health disparities;"
2. summarize some of the data for health disparities;
3. consider the effect of health disparities on communities.

In Preparation

As you prepare to discuss health disparities and link them to ethnic and racial differences, you may want to identify additional studies that demonstrate differences in care among the disciplines represented in your training. You may also want to use available data from your own institution for this discussion.

Steps

1. Ask the group to indicate if they have heard of the term "health disparities" by using a show of hands. Ask them to define the term.

2. Show Overhead IIIB.1 and ask participants how they would modify this definition, if at all.

3. Generate a list of examples of health disparities from the group. Show Overhead IIIB.2 and follow it with Overhead IIIB.3. Ask the group to reflect on what might account for these differences. In this discussion you will want to highlight that a substantial body of data now show that populations have documented disparities in health based on factors such as race/ethnicity, gender, age, income, immigration status, geographic location, access to care, sexual orientation, and language.

4. Show Overhead IIIB.4. Ask the group to identify factors that might explain the differences in prescription of analgesics for whites, but not for Hispanics for the same diagnosis (e.g., cultural descriptions of pain, stereotypes, physician decision-making, patient requests, language, immigrant status, etc.).

5. Review the authors' conclusion, "we doubt that the underuse of analgesics in Hispanic patients occurred because they felt less pain than ...white patients....There may be cultural influences on the expression of pain...one possible explanation is it relates to a failure on the part of physicians, and perhaps other staff members, to recognize the presence of pain in patients who are culturally different from themselves." Ask the group to share their thoughts. Do they agree? Disagree?

6. Indicate that in a follow-up study the authors found that physicians' ability to assess pain severity does not differ for Hispanic and non-Hispanic patients. The authors conclude that "...ethnically based inequality of treatment...does not seem to result from an inability of physicians to assess the pain experience of minority patients...." (Todd KH et al, 1994) Ask for the group's reaction to this statement.

7. Show Overhead IIIB.5. Ask the group to suggest what might account for the difference in findings between these two studies. Discuss with them the conclusion that "subconscious perceptions" may bias physicians' actions. Ask them to share their experiences on this issue.

8. Transition to the next exercise.

OVERHEAD IIIB.1

DEFINING HEALTH DISPARITIES

Health disparities are population-specific differences related to:

- **utilization of services;**
- **health outcomes, including disabilities, disease and death;**
- **access to care;**
- **poorer overall health;**
- **social, economic, cultural and other barriers to optimal health.**

OVERHEAD IIIB.2

LEADING CAUSES OF DEATH IN 1999 BY RACE AND ETHNICITY

Rank	White	Black	Hispanic	Native American	Asian / Pacific Islander
1.	CAD	CAD	CAD	CAD	CAD
2.	Cancer	Cancer	Cancer	Cancer	Cancer
3.	CVD	CVD	AUI	AUI	CVD
4.	Chronic Lung Disease	AUI	CVD	DM	AUI
5.	AUI	DM	DM	CVD	DM

CAD= Coronary Artery Disease
CVD= Cerebrovascular Disease
AUI= Accdents and Unintentional Injuries
DM = Diabetes Mellitus

National Vital Statistics Report, 2001.

OVERHEAD IIIB.3

HEALTHY PEOPLE 2010 FINDINGS

Healthy People 2010 reported:

- **Women of Vietnamese origin in the U.S. have cervical cancer at nearly 5 times the rate for White women.**
- **55% of reported AIDS cases are among African American and Hispanic populations.**
- **Infant mortality rates among American Indians and Alaskan Natives is almost double that of Whites.**
- **Pima Indians of Arizona have one of the highest rates of diabetes in the world.**
- **Evidence suggests that lesbians have higher rates of smoking and obesity than heterosexual women.**

U.S. Department of Health and Human Services, 2001.

OVERHEAD IIIB.4

ETHNIC DIFFERENCES IN USE OF ANALGESICS IN AN EMERGENCY MEDICINE CENTER

ANALGESIA FOR ISOLATED LONG-BONE FRACTURES

	White %	Hispanic %
Analgesic dose		
No analgesic	25.9	54.8
Low dose analgesic	45.4	19.4
High dose analgesic	28.7	25.8
Analgesic class		
No analgesic	25.9	54.8
Nonnarcotic	5.6	0
Narcotic	68.5	45.2

Adapted from Todd, 1993.

OVERHEAD IIIB.5

ROLE OF CLINICIANS IN HEALTH DISPARITIES

Clinical decision-making study with standardized patients who were identical in all aspects except for race and gender:

- Videos shown to 720 physicians
- African Americans 40% less likely to be referred for cardiac catheterization
- African Americans were rated as having lower income, despite the same occupation
- Race and sex of patient affected MD decision to refer patient, even after adjusting for symptoms, estimates of probability and clinical characteristics
- Lowest referral rates were for African American women
- Physician perceptions of patient attributes/personality did not affect outcomes
- Findings "may suggest bias on the part of the physician...could be the result of subconscious perceptions rather than deliberate actions or thoughts."

Schulman, 1999.

Data from study of Medicare beneficiaries hospitalized for acute myocardial infarction (MI) in 1994 and 1995:

- Study of more than 39,715 patients (White and African American)
- Patients treated by 17,550 White and 588 African American physicians
- African American patients were significantly less likely than Whites to undergo cardiac catheterization, regardless of the race of their physician
- African Americans had lower death rates (mortality) at 30 days after MI than Whites, despite lower rate of cardiac catheterizations
- Suggests that "racial discordance does not explain difference between African American and White patients in the use of cardiac catheterization"
- Unable to assess whether cardiac procedures were underused, appropriately used, or overused for either group of patients

Chen, 2001.

Exercise IIIC: The Federal Response to Health Disparities — TIME: 30 MINUTES

Type of Activity
Lecture/Discussion

Purpose
To familiarize participants with federal mandates and guidelines as they relate to health disparities among ethnic and racial minorities.

Learning Objectives
Participants will be able to discuss the legal requirements, guidelines and recommendations related to equal access to health care as described in the Federal Civil Rights law and the 2001 National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health Care.

In Preparation
The Federal CLAS Standards use an expanded definition of cultural competency which you might want to review with the group.

> "Cultural and linguistic competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enable effective work in cross-cultural situations.
>
> 'Culture' refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups. 'Competence' implies having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities." (Cross T, 1989)

MATERIALS

Overhead IIIC.1: Federal Mandates: Title VI

Overhead IIIC.2: Federal Mandates: CLAS Standards

Steps

1. Discuss with the group that equal treatment and care is not a question of choice. It's the law. Show Overhead IIIC.1.

2. Review Overhead IIIC.2. This overhead presents in greater detail the efforts that need to be made to reinforce cultural competence along the continuum of a health care system. You may decide to devote more time to this information and encourage more discussion, depending on the profile of the learners. If you choose to expand this discussion, you may wish to refer to Section IX which outlines improvements that can be made in health care organizations.

3. Transition to the next exercise.

OVERHEAD IIIC.1

FEDERAL MANDATES: TITLE VI

Title VI of the Civil Rights Act of 1964 states:

"No person in the United States shall, on grounds of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance."

- Title VI applies to all recipients of federal funds, without regard to the amount of federal funds that they have received.
- It covers doctors who treat Medicaid or Medicare patients as well as hospitals that receive millions in federal grants.
- Under federal law, providers are not only prohibited from singling out patients based on race or national origin, they cannot employ practices that have a discriminatory impact on individuals based upon their race or national origin.

OVERHEAD IIIC.2.1

FEDERAL MANDATES: CLAS Standards

The collective set of CLAS mandates, guidelines and recommendations issued by the HHS Office of Minority Health is intended to inform, guide and facilitate required and recommended practices related to culturally and linguistically appropriate health services.

Three Themes

1. Culturally Competent Care (Standards 1-3)

- Effective, understandable and respectful care
- Recruitment, retraining and promotion of a diverse staff and leadership
- Ongoing education/training in culturally and linguistically appropriate care for all staff

2. Language Access Services (Standards 4-7): Mandated by current federal requirements for all recipients of federal funds

- Bilingual staff and interpreter services
- Verbal and written notices to patients in their preferred language about their right to receive language assistance services
- Assurance of competent language assistance by interpreters and bilingual staff
- Patient-related materials and signage in common languages of the community

OVERHEAD IIIC.2.2

FEDERAL MANDATES: CLAS Standards (continued)

3. Organizational Supports for Cultural Competence (Standards 8–14)

- A written strategic plan to provide CLAS
- Initial and ongoing organizational self-assessment of CLAS-related activities
- Data on patients' race, ethnicity and language preferences collected in health records and integrated into MIS
- Demographic, cultural and epidemiological profile of the community and needs assessment data used for planning and service delivery
- Partnership with community to design and implement CLAS-related activities
- Conflict and grievance resolution processes are culturally and linguistically sensitive to resolving cross-cultural conflicts/complaints

U.S. Department of Health and Human Services, Office of Minority Health, 2001.

SECTION IV *Culture: The Patient's Perspective*

Introduction

In Section IV we begin to explore the health care beliefs and practices that patients bring to the clinical encounter. The concepts of disease and illness are defined from the perspectives of the patient and the clinician to demonstrate how easy it can be to misunderstand our patients' expectations for care.

Considerable time is devoted to the concept of "culture-bound syndromes." While there is controversy about the use of this phrase as an explanation of disease, we have found it to be a useful means of describing cultural influences on health and illness. If you wish to use this material we recommend that you combine descriptions of "western" as well as "non-western" culture-bound syndromes and couple this with a discussion of stereotypes and generalizations (see Exercise IVD).

The curriculum then turns to a description of folk medicine and traditional healers. Our goal is to inform learners of health behaviors that they may not be aware of and to encourage them to consider how they might integrate this information into their practices. Subsequent sections focus on new communication techniques that can assist in this process.

The section concludes with an exercise demonstrating the difference between stereotypes and generalizations. This information is included as a reminder that our natural inclinations to make generalizations about groups of individuals can be misleading and result in stereotyping. You may choose to use this exercise earlier or during subsequent sections of your trainings.

Learning Objectives

At the conclusion of Section IV the learner will be able to:

1. distinguish between illness and disease as seen from different perspectives;
2. describe how explanations of disease etiology can differ among cultures;
3. give examples of culture-bound syndromes;
4. explain how the concept of culture-bound syndromes can be useful in understanding patients' views of illness;
5. describe examples of traditional healing methods;
6. explain the difference between generalizations and stereotypes.

TIME: 45 MINUTES

Exercise IVA: Disease and Illness: Understanding the Patient's Experience

MATERIALS

Overhead IVA.1: Definitions of Disease

Overhead IVA.2: Disease vs. Illness

Handout IVA.3.1–IVA.3.2: Case Studies: Mr. Raj Singh and Mrs. Su Yong

Overhead IVA.4: Working with Cultural Differences

Type of Activity
Lecture/Discussion

Purpose
To help participants understand how care can be improved by recognizing differences in a patient's and clinician's understanding and experience of disease and illness.

Learning Objective
Participants will be able to describe some differences that may exist between a patient and clinician in understanding disease and illness.

Steps

1. Ask participants to describe experiences where a patient had a different explanation for his/her illness than they did.

2. Present Overheads IVA.1 and IVA.2. Discuss the implications for patient care of these different definitions of illness and disease.

3. Distribute Handout IVA.3. Divide participants into small groups of 3–5 and have them read the first case study and answer the discussion questions. After 10 minutes, ask the small groups to go on to the second case.

4. Reconvene the entire group and ask learners to discuss their responses to discussion questions 3 and 4 for each case. Are there similarities in their responses for the two cases? Ask the group to describe examples of the next steps they identified for working with each patient.

5. Present Overhead IVA.4 and explain the importance of understanding and working with the patient's explanation of his/her illness. Ask for the group's reactions to the quote on the overhead. Mention that cultural values and norms strongly influence the experience and interpretation of illness, as well as the type of care patients seek and accept.

6. Transition to the next exercise.

OVERHEAD IVA.1

DEFINITIONS OF DISEASE

Navajo: Lack of harmony in and with the universe.

World Health Organization: Anything less than a complete state of physical, social and mental well-being.

FDA: Any deviation from, impairment of or interruption of the normal structure or function of any part, organ or system (or combination thereof) of the body that is manifested by a characteristic set of one or more signs or symptoms, including laboratory or clinical measurements that are characteristic of a disease.

OVERHEAD IVA.2

DISEASE VS. ILLNESS

Disease

"A theoretical construct, or abstraction, by which physicians attempt to explain patients' problems in terms of abnormalities of structure and/or function of body organs and systems and includes both physical and mental disorders."*

"Abnormalities in the structure and function of body organs and systems."**

Illness

"Patients' personal experiences of ill health."*

"...personal, interpersonal and cultural reactions to disease or discomfort...shaped by cultural factors governing perception, labeling, explanation and valuation of the discomforting experience."**

*Stewart, 1995.

**Kleinman, 1978.

HANDOUT IVA.3.1

CASE STUDY: MR. RAJ SINGH

Mr. Raj Singh is a seventy-two-year-old Sikh from India who has suffered a heart attack. His son, a physician, has brought him to the hospital. The Sikh religion forbids cutting or shaving any body hair and orthodox Sikhs always carry a dagger to use against anyone who might force them to do something prohibited by their religion.

Mr. Singh is scheduled for a heart catheterization to determine the extent of blockage in his coronary arteries. A catheter will be run to the heart from the femoral artery which is located in Mr. Singh's groin. His son has explained the procedure to him in detail.

The nurse has arrived in his room and has explained that she must shave the hair in the groin to prevent infection. As she approaches him with the razor Mr. Singh pulls out a small sword and begins waving it at her. When she says she will ask a male nurse to shave him, Mr. Singh angrily yells, "No shaving of hair by anyone!"

You, the physician who will perform the catheterization, are unaware of Sikh beliefs and practices. You have been told by the nurse that Mr. Singh refuses to be shaved. You want the procedure to go smoothly and don't understand why Mr. Singh is being difficult. Also, you are concerned that he has brandished a sword at the nurse.

Discussion Questions:

1. Since you are unaware of Sikh beliefs, what might be your explanation of Mr. Singh's behavior and of his refusal to be shaved?

2. How does Mr. Singh perceive the attempts of the nurse to shave his hair?

3. How are your and Mr. Singh's perceptions at odds?

4. What do you think about Mr. Singh's refusal to have his hair shaved?

5. What would be your next steps in working with Mr. Singh?

Developed by Carol Allen, UCSF Center for the Health Professions.

HANDOUT IVA.3.2

CASE STUDY: MRS. SU YONG

Mrs.Su Yong is a nineteen year-old Vietnamese woman who has returned to the hospital twelve days after giving birth. She has been practicing a version of the traditional lying-in period observed throughout much of Asia and Latin America. For a period of time after a woman gives birth, her body is thought to be weak and especially susceptible to outside forces. To guard against such forces, Mrs. Yong has chosen to avoid exercise and bathing and to eat only "warm" or "hot" foods, which will help restore her loss of yang.

Mrs. Yong presents with high fever and abdominal pain. During her stay in the hospital she rejects most of the food and liquids prepared by the hospital, refuses to shower or wash her hair and will get out of bed only to use the bathroom. She insists on covering herself with mounds of blankets despite her high temperature and sweating. The team is fearful that her health is deteriorating and that her traditional practices are interfering with her care.

The patient believes that if she does not follow the practice of lying-in she might suffer aches, pains, arthritis and other ailments when she is older. She believes she is practicing preventive care.

You are aware of the tradition of lying-in, but are unsure of its meaning to your patient.

Discussion Questions:

1. What is your explanation of Mrs. Yong's health problem?
2. What is Mrs. Yong's perception of her illness?
3. How are your and Mrs. Yong's interpretations of her problem at odds?
4. What do you think about Mrs. Yong's practice of lying-in?
5. What would be your next steps in working with Mrs. Yong?

Developed by Carol Allen, UCSF Center for the Health Professions.

OVERHEAD IVA.4

WORKING WITH CULTURAL DIFFERENCES

"Without some agreement about the nature of what is wrong, it is difficult for a doctor and a patient to agree on a plan of management acceptable to both of them. It is not essential for the physician actually to believe that the nature of the problem is as the patient sees it, but the doctor's explanation and recommended treatment must be at least consistent with the patient's point of view."*

* Stewart, 1995.

TIME: 60 MINUTES

Exercise IVB: Folk Illnesses and Culture-Bound Syndromes

MATERIALS

Overhead IVB.1: Different Explanations of Disease Etiology

Overhead IVB.2: Definition of Culture-Bound Syndromes

Handout IVB.3.1 – IVB.3.3: Culture-Bound Syndromes

Type of Activity
Lecture/Discussion

Purpose
To explore cultural differences in explanations of disease etiology as well as the phenomenon of "culture-bound syndromes." Participants will learn several common folk illnesses and will explore a broader definition of the term "culture-bound syndrome."

Learning Objectives
Participants will be able to:
1. articulate some of the major cultural differences in disease etiology;
2. list the characteristics of some common culture-bound syndromes.

In Preparation
This discussion requires skillful facilitation. If you are not familiar or comfortable with the content, consider partnering with a medical anthropologist, mental health professional or others who may have expertise in this content. You will need to anticipate questions such as stereotypes, generalizations, definition of culture, and the continuum of cultural competence.

Steps

1. Describe to learners that not all cultures explain illness using the biomedical paradigm. In order to communicate more effectively with patients, it is important to understand different explanations of illness that clinicians may encounter.

2. Present Overhead IVB.1. Remind the group that given the tremendous variation across and within ethnic groups, there may be instances where different explanations of disease co-exist. Alternatively, individuals and groups may deviate from traditional health and illness beliefs because of migration, acculturation or other factors. For the clinician, it is most important to check assumptions about the patient's beliefs before proceeding. Give a brief description of the meaning and origin of each explanation. Ask participants if they have encountered any of these explanations and inquire how they addressed them.

- **Upset in body balance:** The healthy body is in a state of balance between hot and cold, which refer to qualities rather than temperatures. When a person becomes ill, it may be due to an imbalance between hot and cold. Treatment may involve eating certain types of food or herbs, with the goal of restoring balance to the system.

- **Yin and Yang:** Illness is seen as a disturbance in the balance of Yin and Yang, caused by emotions, too much or too little heat or cold or other influences. Health is reclaimed by restoring balance to the body or the mind.

- **Soul loss/theft:** The soul has either left the body or been stolen and the body is left weakened and ill. Treatment usually requires a shaman, who "leaves" his or her body to look for and return the missing soul.

- **Spirit possession:** A person's body is taken over by a spirit that causes the person to act in ways that s/he normally would not. The treatment includes exorcism.

- **Breach of taboo:** Illness or injury is perceived as punishment by the gods for breaking religious or social customs. The punishment can focus on the transgressor or someone else with a relationship to the transgressor.

- **Object intrusion:** A magical foreign object enters the body and causes illness. Treatment usually involves removing the object, usually by a shaman.

3. Remind the participants that it is important not to assume that patients will experience their illness in a certain way just because they are from a culture where that explanation may be common. For example, not all patients of Chinese culture will use yin-yang as an explanation for illness. Also, clinicians should be prepared for patients who may not readily share their health beliefs. Lack of adherence to treatment plans, lack of trust, dissatisfaction and conflict may all be clues to cultural difference between patient and clinician.

4. Ask if anyone can define "culture-bound syndrome." Present Overhead IVB.2. Ask for examples of culture-bound syndromes in the U.S.

5. Distribute Handout IVB.3. Explain that there is not one agreed upon definition for a given culture-bound syndrome; different sources may have different descriptions of them.

6. Ask participants to look at the list at the end of the handout. Discuss the fact that these are not usually recognized as culture-bound syndromes.

   - Why is this?

   - Do they see these disorders as culture-bound syndromes? Why or why not?

7. Engage participants in a discussion about this. Keep in mind that some may be defensive, so you'll want to facilitate rather than lecture. Ultimately, you want to help them see why the term culture-bound syndrome can be considered ethnocentric because it assumes some diseases are "real" whereas others are culturally determined. While clinicians may see some illnesses as culture-bound and others not, in fact all illnesses are influenced by their cultural context. Every syndrome or condition, no matter how unusual it may seem to an outsider, has an important social meaning and function in its cultural context.

   The concept of culture-bound syndrome is therefore useful in that it raises awareness of the cultural context of illnesses and symptoms. This awareness allows clinicians to incorporate this understanding into treatment plans that are more culturally appropriate for their patients.

8. Transition to the next exercise.

OVERHEAD IVB.1

DIFFERENT EXPLANATIONS OF DISEASE ETIOLOGY

- Upset in body balance
- Yin and Yang
- Soul loss/theft
- Spirit possession
- Breach of taboo
- Object intrusion

Adapted from Galanti, 1997.

OVERHEAD IVB.2

DEFINITION OF CULTURE-BOUND SYNDROMES

Culture-bound syndromes are:
"...generally limited to specific societies or cultural areas and are localized, folk, diagnostic categories that frame coherent meanings for certain repetitive, patterned and troubling sets of experiences and observations."

DSM-IV, 1994.

HANDOUT IVB.3.1

CULTURE-BOUND SYNDROMES

Problem	Where Recognized	Description
Amok	Malaysia Laos	Outburst of aggressive and violent behavior percipitated by slight/insult. Only seen in men.
Ataque de nervios/Nervios	Latin America Caribbean	Uncontrollable shouting, crying, trembling, and aggression typically triggered by a stressful family event.
Bebainan	Bali	Individual suddenly breaks into tears and tries to run away; ultimately collapses with exhaustion and later has no memory of the episode.
Boufée delirante	Haiti West Africa	Sudden aggressive behavior, confusion, agitation; sometimes with visual and auditory hallucinations.
Dhat	India Sri Lanka	Severe anxiety and hypochondria associated with discharge of semen; feelings of weakness and exhaustion.
Empacho	Mexico South America	Abdominal pain, vomiting and bloating believed to be due to food clinging to intestinal wall. More common in children.
Falling-out/ Blacking out	Southern U.S. Caribbean	Sudden collapse. Eyes are open, but unable to see. Feels powerless to move.
Ghost sickness	Native American	Preoccupation with death. Symptoms include weakness, bad dreams, feelings of danger, dizziness, hallucinations, and anxiety.
Hwa-byung "anger syndrome"	Korea	Insomnia, fatigue, panic, fear of impending death attributed to suppression of anger.

HANDOUT IVB.3.2

CULTURE-BOUND SYNDROMES (Continued)

Problem	Where Recognized	Description
Koro	China Thailand	Belief that sexual organs are receding into body; associated with anxiety and fear of imminent death.
Latah	Malaysia Japan	Hypersensitivity to sudden fright; trance-like behavior.
Mal de ojo "evil eye"	Latin America, Mediterranean	Fitful sleep, crying, diarrhea, vomiting, and fever. Especially common in children.
Nyuab Siab (Difficult Liver)	Hmong	Excessive worry, crying, confusion, loss of appetite and delusions. Caused by loss of family, status, home, country or any important item that has a high emotional value.
Pica	U.S.	Craving for non-food like dirt, clay, and chalk. Prevalent among pregnant women.
Qi-gong (psychotic reaction)	China	Acute time limited psychotic behaviors after engaging in qi-gong exercise.
Spell	Southern U.S.	Trance where individuals can communicate with spirits.
Susto (fright or soul loss)	South America Mexico	Anxiety, anorexia, insomnia, phobias and other symptoms attributed to a frightening event causing the soul to leave body.
Taijin Kyofusho	Japan	Intense fear that one's body or bodily functions give offense to others.
Zar	Ethiopia, Egypt, Sudan, Iran	Possession by spirit causing shouting, dancing, head banging, and apathy.

*Adapted from DSM-IV, 1994.

HANDOUT IVB.3.3

CULTURE-BOUND SYNDROMES IN THE U.S?

- Type A behavior
- Agoraphobia
- Low back pain
- Anorexia Nervosa
- Bulimia

TIME: 30 MINUTES

Exercise IVC: Folk Medicine and Traditional Healers

MATERIALS

Overhead IVC.1: The Evolution of Health Care

Overhead IVC.2: U.S. Patterns in Alternative Medicine Usage, 1990-1997

Overhead IVC.3: Traditional Healing Methods

Type of Activity

Lecture/Discussion

Purpose

To teach participants about the prevalence and the usage of complementary and alternative medicines and explore reasons that patients may not share this information with clinicians. The possible negative consequences of combining pharmaceutical drugs and herbal remedies are addressed. Participants explore ways to make patients feel more comfortable and willing to share information about their use of traditional remedies and healers.

Learning Objectives

Participants will be able to:

1. describe what is known about patterns of use of alternative medicine;
2. describe common traditional healing methods used in the U.S.;
3. articulate reasons that patients may not disclose use of alternative medicine practices.

In Preparation

In this section, it may be useful to add an overhead or handout about a specific traditional healing practice commonly used by local patient populations. For example, in an area with a large Mexican population, it may be useful to explain the roles of a *curandero/a.*

Steps

1. Present Overhead IVC.1. Though somewhat tongue in cheek, this overhead provides a view of how healing practices have changed over time. Explain that while western medicine has made remarkable advances, some people turn to traditional healing practices for a variety of reasons.

2. Present Overhead IVC.2. Discuss the prevalence of "alternative" medicine use and the fact that many patients do not tell their physicians that they are seeing a traditional healer. Ask participants to identify reasons why this is the case. The data in the overhead show an increase in use of alternative therapies and practitioners since 1990.

3. Present Overhead IVC.3. These are a sample of traditional healing methods being used in the U.S. We have chosen them because they are widely practiced and not always understood by clinicians. Describe each method as you discuss it. You may want to include pictures depicting their use.

   - **Coin rubbing (coining):** Rubbing the body with a coin in order to draw out illness. Often produces a raised red area, giving the appearance that the illness has been brought to the surface of the skin. It is believed that this redness will only appear in people who are ill, which is seen as evidence to support the technique.

   - **Cupping:** A glass is heated and placed on the body, creating suction and leaving a red circular mark. Cupping is believed to draw out spirits causing illness and equalize an imbalance in the body. Health care workers have misinterpreted both cupping and coining as child abuse.

   - **Treating fever:** People in many cultures believe that the best treatment for a fever is to keep the person warm and let them sweat out the fever. This runs contrary to the current medical practice of cooling the body in order to reduce fever.

   - **Acupuncture:** Thin needles are placed into the skin at certain points or channels called meridians. The vital force energy is thought to flow through the meridians. Too little or too much energy flowing along the meridians is believed to create the imbalance that causes pain and illness.

   - **Ayurveda:** A system of care in which there are three basic human metabolic types (doshas) that are linked to certain physical characteristics and to body organs. Treatment is aimed at correcting organ system, or dosha, imbalance.

   - **Homeopathy:** Based on the idea that large doses of a substance cause a symptom, while very small doses of that same substance will cure it. Homeopathic remedies are made from substances diluted thousands of times in water or alcohol.

- **Shamanism:** The soul of the shaman or healer, in an ecstatic trance state, is believed to leave the body and communicate with spirit helpers in the nether realms. The spirit helpers give the shaman the power or knowledge to return to ordinary reality to fight the illness of the patient, give advice for serious problems or re-establish the balance of the community.

4. Ask participants the following questions:

   - Why might a patient be reluctant to discuss traditional healing methods with their clinician?

   - How might the withholding of this information affect medical care? At this point it is important to discuss the possible additive effects or negative interactions between pharmaceutical drugs and herbal or other traditional medicines. See references for resources for doing this.

   - What do you need to do to help your patients feel more comfortable discussing their use of traditional healers and medicines? What questions can you ask?

   - What would you do if you learned that your patient is taking an herbal medicine that you have never heard of?

5. If there is time, brainstorm answers to the following question:

   - What are some cultural explanations for "non-adherence?" How is this an ethnocentric term?

6. Transition to the next exercise.

OVERHEAD IVC.1

THE EVOLUTION OF HEALTH CARE*

2000 BC	**"Here, eat this root."**
1000 AD	**"That root is heathen. Here, say this prayer."**
1850 AD	**"That prayer is superstition. Here, drink this potion."**
1940 AD	**"That potion is snake oil. Here, swallow this pill."**
1985 AD	**"That pill is ineffective. Here take this antibiotic."**
2000 AD	**"That antibiotic doesn't work. Here, eat this root."**

* Source unknown.

OVERHEAD IVC.2

U.S. PATTERNS IN ALTERNATIVE MEDICINE USAGE, 1990–1997

Alternative medical (AM) therapies are defined as interventions neither taught widely in medical schools nor generally available in U.S. hospitals.

	1990	1997
% who report using at least 1 of 16 therapies*	33.8%	42.1%
% of AM users who visited an alternative medicine practitioner	36.3%	46.3%
% of AM users who disclosed usage to physician	39.8%	38.5%
Visits to AM practitioners— (extrapolated to U.S. population)	427 million	629 million (47.3% estimated increase) Exceeds total visits to all U.S. primary care physicians.
Estimated out-of-pocket expense for visits to AM practitioners (does not include alternative medicines, megavitamins, etc.)	$14.6 billion	$21.2 billion (45% estimated increase)

* includes herbal medicine, massage, megavitamins, self-help groups, folk remedies, energy healing, homeopathy.

Adapted from Eisenberg, 1998.

OVERHEAD IVC.3

TRADITIONAL HEALING METHODS

- Coin rubbing (coining)
- Cupping
- Treating fever
- Acupuncture
- Ayurveda
- Homeopathy
- Shamanism

TIME: 30 MINUTES

Exercise IVD: The Difference Between Stereotypes and Generalizations

MATERIALS

Flipchart/markers

Handout IVD.1: Common Ethnic Stereotypes

Type of Activity
Discussion

Purpose
Generalizations are often used to summarize cultural beliefs and practices. This exercise will help participants understand the difference between a stereotype and a generalization. Participants will begin to consider some of their own stereotypes and to recognize the negative impact they can have on clinical care.

Learning Objectives
Participants will be able to:
1. define stereotypes and explain the negative impact they can have;
2. describe the difference between a stereotype and a generalization.

Steps

1. Explain that this exercise will focus on stereotypes and the negative effects they can have. Explain that during this exercise you will ask participants to share their responses with others, if they feel comfortable doing so.

2. Explain the difference between a stereotype and a generalization. Think of a generalization as a starting point. It points to common trends, but more information is needed to determine whether a statement is appropriate to an individual. A stereotype is an ending point; no attempt is made to learn if an individual fits the statement. Give the following example:

   > An example is the assumption that Mexicans have large families. If I meet Rosa, a Mexican woman, and I say to myself, "Rosa is Mexican; she must have a large family," I am stereotyping her. But if I think, "Mexicans often have large families; I wonder if Rosa does," I am making a generalization. (Galanti, 1997)

3. Ask participants to write down their own stereotypes, or ones they've heard, about physicians or other health care professionals in the U.S. After a couple of minutes, ask participants to contribute items from their lists while you chart them in front of the group.

4. Ask what effect these stereotypes have had on participants or their colleagues.

5. Mention that stereotyping is a natural human tendency — we all label people — but that it can be very harmful. Ask participants for an example. If they can't come up with one, use the following example or one from your own experience:

   > In many health care facilities in California, the housekeeping staff is composed primarily of Latino/a employees. A possible stereotype would be that because of effective job performance by these employees, all Latino/as would be slated for housekeeping and none for accounting, the business office, health professions, etc.

7. Distribute Handout IVD.1 and ask participants to read the directions and fill it out individually. Emphasize that this information was gathered in a 1999 survey conducted by the Henry J. Kaiser Family Foundation.

8. When they are finished, start the discussion by asking the participants how they felt as they filled out the worksheet. Begin by discussing consumers' views of what health professionals believe. What are participants' thoughts about the impact of these stereotypes on health care? Continue on to the list of stereotypes held by health professionals. What are the possible effects of these beliefs on health care? Ask participants to consider:

   - How do stereotypes shape the care that is provided in your work setting?
   - What can you do to lessen the harmful effects of stereotypes?

9. If ideas are difficult to elicit from participants, offer suggestions from your own experience. End the discussion by briefly summarizing what was learned.

10. Transition to the next exercise.

HANDOUT IVD.1

COMMON ETHNIC STEREOTYPES

Below is a list of stereotypes that "minority" health care consumers believe that health care professionals hold. Have you heard your colleagues describe their patients in this way? What might be the outcome for care if health care professionals believe these descriptions?

Stereotype	Held by my colleagues	Potential Impact on Care
1. African Americans, Native Americans and some Hispanics (esp. young males) are not able to pay for services.		
2. African Americans over-utilize the ER.		
3. All young African American mothers are unmarried.		
4. Asians are compliant, deferential and non-assertive.		
5. Native Americans are more likely to be drunk than ill.		

Below is a list of stereotypes that some health care professionals hold. Have you heard your colleagues describe their patients in this way? What might be the outcome for care if health care professionals believe these descriptions?

Stereotype	Held by my colleagues	Potential Impact on Care
1. Asians won't discuss symptoms or complain.		
2. Obtaining medical history information from immigrants is impossible.		
3. Native Americans don't show emotion.		
4. Asians won't complete prescription drug regimens.		
5. Hispanics and African Americans won't lose weight or eat healthy diets.		

Adapted from Kaiser Family Foundation, 1999.

SECTION V *Communicating Across Cultural Differences*

Introduction

In previous sections the focus has been on exploring how one's culture can influence the delivery and acceptance of health care. We have considered ways in which patients and clinicians differ in their explanations of disease and illness. Section V now turns to the clinician-patient relationship and focuses on the complexities of cross-cultural communication in that context.

We discuss how communication cues can be interpreted differently, depending on one's culture, and review behaviors that may lead to misunderstandings in clinical interactions. We look at verbal and non-verbal communication in a cultural context to understand how they can affect the clinical encounter. The final exercise includes cases that provide an opportunity for learners to practice new strategies in cross-cultural communication.

Section V provides the necessary preparatory work for the next section in which the focus will be on using different communication models in the clinical encounter.

Learning Objectives

At the conclusion of Section V the learner will be able to:

1. describe some cultural components of communication behaviors;
2. identify cultural differences that may affect clinician-patient communication;
3. identify solutions to bridging cultural differences in communication.

TIME: 30 MINUTES

Exercise VA: Misunderstandings in Cross-Cultural Communication

MATERIALS

Handout VA.1: Challenges to Cross-Cultural Communication

Type of Activity
Discussion

Purpose
To explore emotional reactions to specific behaviors and to begin to understand the cultural sources of these behaviors.

Learning Objective
Participants will be able to list possible cultural explanations for challenging communication interactions.

Steps

1. Explain that different communication styles can trigger emotional reactions. How do you feel when someone does not make eye contact with you or when they show no facial expression when you speak to them? We may experience frustration, irritation or confusion when someone behaves in a way that does not correspond with our preferences. This is more likely to happen in interactions in which people do not share cultural backgrounds.

   The more aware we are of our own behaviors and preferences, and the greater our understanding of the role of culture in communication, the less likely we are to feel annoyed, frustrated or confused when we encounter differences.

2. Distribute Handout VA.1 and ask participants to put a check next to the behaviors they find the most difficult. Ask them to also to write their typical reactions to the behaviors they checked as well as reasons they find the behavior irritating. Tell participants that they will have about 10 minutes to complete the handout.

3. When they are finished, divide participants into small groups of 3 to 5 people. Ask the groups to share their responses and to try to identify possible cultural explanations for the behaviors.

4. Bring the group back together after about 10 minutes and lead a short discussion on the participants' new insights and perspectives. Close by encouraging participants to explore possible cultural explanations for a behavior when faced with challenging interactions.

5. Transition to the next exercise.

HANDOUT VA.1

CHALLENGES TO CROSS-CULTURAL COMMUNICATION

Directions: Check any of the following behaviors that could result in frustration or negative interactions between you and a patient, family member or colleague. As you read each item, jot down your typical reaction to that behavior.

- ☐ Nodding or saying "yes" even though they do not understand.
- ☐ Speaking in a language other than English.
- ☐ Deferring to others when asked a question.
- ☐ Speaking loudly.
- ☐ Lacking nonverbal feedback (e.g., facial expression, nodding).
- ☐ Speaking softly.
- ☐ Avoiding eye contact.
- ☐ Smiling and laughing when nothing is humorous.
- ☐ Giving a soft, limp handshake.
- ☐ Standing very close to you when talking.
- ☐ Speaking with a heavy accent or limited English.
- ☐ Making small talk and not getting to the point.
- ☐ Not providing necessary information.
- ☐ Not taking the initiative to ask questions.
- ☐ Calling/not calling you by your first name.
- ☐ Discounting, avoiding or refusing to deal with you because of your gender.
- ☐ Asking personal questions.
- ☐ Using formal titles in addressing people.

Adapted from Gardenswartz, 1999.

TIME: 45 MINUTES — Exercise VB: Communication Styles

MATERIALS

Overhead VB.1: Levels of Communication in Health Care

Overhead VB.2: Barriers to Cross-Cultural Communication

Overhead VB.3: Verbal and Nonverbal Communication

Type of Activity
Lecture / Discussion

Purpose
To help participants consider how different communication styles affect clinical interactions and to identify some strategies for working with these styles.

Learning Objectives
Participants will be able to:
1. list several different communication styles;
2. discuss how different styles may affect clinical interactions and;
3. articulate some strategies for working effectively with different communication styles.

Steps

1. Begin by explaining that while we may assume that the most important aspect of communication is verbal, in fact we communicate much of our meaning nonverbally. Interpreting nonverbal communication can be particularly challenging when we are interacting with someone from a different culture. Assuming that everyone shares our communication behaviors and preferences can lead to misunderstandings.

2. As background information, review Overhead VB.1. Explain that there are multiple levels of communication, ranging from societal to inter- and intrapersonal interactions. For the purposes of this exercise we will focus on interpersonal communication.

3. Review Overhead VB.2. With each barrier, ask participants to describe a situation they have been in where they have found it difficult to communicate because of this barrier. As an alternative, you might simply review the list of barriers as a reminder of how complicated cross-cultural communication often can be.

4. Turn to Overhead VB.3. Explain that in the clinician-patient encounter, there are a number of communication cues to be aware of in order to conduct an effective interview. Go over each of the elements of communication. Elicit real-life experiences from the participants as you go down the list, or share your own. Questions to ask participants:

   - How did you deal with this difference when you encountered it?
   - What mistakes did you make? How did you learn from your mistakes?
   - Why do we tend to make judgements when we encounter difference?

During the discussion, give concrete examples to illustrate the significant differences that can exist in each aspect of communication.

- **Language**: Is there a language barrier? How can you tell? Mention the common misperception that people with an accent do not speak English fluently. How might you determine the patient's level of fluency and whether an interpreter is needed? You might remind participants that language barriers can also exist even when both patient and clinician speak the same language (e.g. use of technical terms, idioms).You may want to discuss the issue of spoken versus written language and literacy.

- **Degree of directness**: Many cultures value indirect communication. What about people in the U.S.? Health care professionals? Mention that most U.S.-born Americans fall on the direct end of the direct-indirect spectrum of communication, although women are generally more indirect than men in our culture. What type of communication is valued in our culture? In medicine? What happens if a clinician who values direct communication is working with a patient who doesn't answer questions directly? When we encounter this type of difference, what are some strategies we can use?

- **Facial expressions/gestures/eye contact**: These vary widely by culture. Give specific examples such as smiling can be a sign of embarrassment or confusion in many Asian cultures, direct eye contact is considered disrespectful in many cultures and the use and meaning of hand gestures varies greatly. How might you learn about appropriate interpretation of expressions and gestures for patients in your area?

- **Touch**: Cultures have different rules about who can be touched and where. What strategies can you use to ensure that you don't offend a patient?

- **Loudness/pitch**: What is considered a normal tone of voice in one culture may be considered aggressive and angry or passive and childlike in another culture. In addition, people may speak more loudly when they are interacting with someone who has limited English ability. What are more effective ways of bridging language barriers? (Speak more slowly, use simpler sentences, avoid idioms and technical terms.)

- **Silence**: Silence makes many U.S.-born Americans uncomfortable. What is the meaning of silence for you? What are some other explanations for silence?

- **Appropriate subjects for conversation**: In some cultures, thoughts, feelings and problems are kept to oneself. How can this affect the patient-clinician interaction? What techniques can you use to work respectfully with patients who are uncomfortable sharing personal information?

5. Ask the group to identify other elements of communication that may have been omitted. How can these elements affect health care experiences?

6. Transition to the next exercise.

OVERHEAD VB.1

LEVELS OF COMMUNICATION IN HEALTH CARE

Societal
Involves coordination of many organizations representing government, industry and education to fulfill societal goals of peace, prosperity and health.

Organizational
Promotes the sharing of information by encompassing intrapersonal, interpersonal and group communication. Links the formal and informal channels of communication to connect different task groups and hierarchies within the organization.

Group
The interaction of three or more individuals to adapt to their environment and achieve shared goals.

Interpersonal
The interaction between two individuals that enables them to develop and maintain a relationship. Often referred to as relational or dyadic communication.

Intrapersonal
Basic level of communication where we interact with ourselves in interpreting reality and creating messages for communicating with others.

OVERHEAD VB.2

BARRIERS TO CROSS-CULTURAL COMMUNICATION

- Cultural context of communication
- Perceptions and stereotypes
- Roles (authoritative figures and gender roles)
- Personal vs. impersonal style of communication
- Role of family
- Non-verbal cues
- Language, literacy and use of interpreters
- Respect

OVERHEAD VB.3

VERBAL AND NONVERBAL COMMUNICATION

- Language (spoken and written)
- Degree of directness
- Facial expressions/Gestures/Eye contact
- Touch
- Loudness/Pitch
- Silence
- Appropriate subjects for conversation

TIME: 60 MINUTES

Exercise VC: Culture and Communication in Clinical Interactions

MATERIALS

Handout VC.1.1–VC.1.4: Case Studies

Flipchart/markers

Type of Activity
Discussion

Purpose
To give participants an opportunity to apply the information learned in Exercises VA and VB to cases where communication problems arise between a patient and clinician.

Learning Objective
Participants will be able to evaluate a case involving a patient and clinician from different cultures and describe solutions to bridging differences in communication styles.

Steps

1. Divide group into small groups of 3 to 5 participants. Give each group a different case study.

2. Ask each group to read their case and answer the discussion questions. Mention that the cases will deal with a variety of cultural differences; including communication styles.

3. Give the groups 15 minutes to discuss and then reconvene into the large group. Ask for representatives from several groups (as many as you have time for) to present their case and a brief summary of their discussion.

4. The following is a list of important cultural and communication issues for each case study. These notes can be used in a discussion during and after each small group presents their conclusions.

   - **Case 1: Status/respect for elders; formality**
     Many people raised in the U.S. consider the use of first names a sign of friendliness and equality. However, some cultures consider using a first name with anyone other than a close friend or family member to be inappropriate. African Americans often show respect to elders by using the formal Mr./Miss./Mrs./Ms. with the last name. Additionally, Mrs. Jones might be sensitive to lack of respect from a white man. And lastly, Dr. Hancock showed a lack of sensitivity by introducing himself by his last name while simultaneously using Mrs. Jones' first name. Ask the group for examples of other cultures for whom using someone's last name is an important sign of respect.

- **Case 2: Facial expressions/gestures; dignity/face-saving**
  Many Asian cultures place a high value on dignity and self-image. If the Luceros had indicated that they did not understand Angie's instructions, they would have lost dignity for not understanding or would have caused Angie to lose hers for not explaining the material well enough. By pretending to understand, the Luceros felt they were preserving everyone's dignity. It is important for clinicians to remember that smiling and nodding do not necessarily signal understanding or agreement for some patients.

- **Case 3: Individual vs. group orientation; informed consent; locus of control; degree of directness**
  In Japan, patients are often not told that they have cancer, especially in the case of a terminal diagnosis. For example, it is common for a physician to tell a patient with stomach cancer that they have an ulcer. Families usually support this decision, as they feel that a diagnosis of cancer would lead to a loss of hope and feelings of guilt about placing a burden on one's family. Informed consent is not mandated in Japan, as it is in the U.S., so disclosure of the diagnosis is usually left to the discretion of the physician and the patient's family. In the U.S., however, a high value is placed on the patient's right to know, and it is assumed that the individual patient will want to make his/her own health care decisions. How should we proceed when these two systems meet, as in the case presented here?

- **Case Study 4: Privacy; touch (gender of clinician/patient); female modesty**
  In many cultures, female modesty is highly valued and men may make most health care decisions for their wives or daughters. In addition, it is taboo in some cultures for a male doctor to see a female patient and vice versa. How can a life-threatening situation, such as the one presented in this case, be dealt with when the only clinician present is of the opposite gender of the patient?

5. Transition to the next exercise.

HANDOUT VC.1.1

CULTURE AND COMMUNICATION CASES

Case # 1

Yvonne Jones, an African American woman in her 50s, has come in for her yearly physical examination. Her regular doctor is not available so she will be seeing Dr. Hancock, whom she has never met. The doctor, a Caucasian man approximately the same age as Mrs. Jones, enters the exam room and introduces himself, saying, "Hello Yvonne, I'm Dr. Hancock. It's nice to meet you." Dr. Hancock continues with the examination and notices that Mrs. Jones is quiet and unresponsive to many of his questions, although she had been smiling and friendly when he first walked in the room. He is concerned that he might have missed important information about her health history because of her reticence, but no matter how friendly he tries to be, she remains reluctant to talk.

Discussion Questions

1. What type of miscommunication happened between Mrs. Jones and Dr. Hancock?
2. What cultural factors influenced this interaction?
3. Why do some Americans prefer to be on a first name basis?
4. How do you decide whether to address your patients by their first or last names?

Ackerman, 2000.

HANDOUT VC.1.2

CULTURE AND COMMUNICATION CASES

Case # 2

Angie, on African American nurse practitioner, is giving instructions for o complicoted regime of medicotions thot Joonne Lucero, o Filipino potient, will be toking. Mrs. Lucero's husbond speaks more English thon she does, so he is serving os on interpreter. While Angie is giving her explonotion, Mrs. Lucero ond her husbond nod and smile. Angie feels confident thot both of them understond when ond how Mrs. Lucero should take the medicotions.

When Mrs. Lucero returns for o follow-up visit in o week, however, it turns out thot she hos not been toking the medicotions occording to Angie's instructions. When she osks Mrs. Lucero ond her husbond to tell her what they understood of her instructions, they oppeor to have understood very little. Angie is very puzzled about whot could hove gone wrong.

Discussion Questions

1. What type of miscommunicotion occurred between Angie ond the Luceros?

2. When a person smiles ond nods, whot does this generally meon to o listener roised in the U.S.? Whot could it mean to the Luceros?

3. How could Angie hove verified the Luceros' understonding of her instructions in the given scenario?

Ackerman, 2000.

HANDOUT VC.1.3

CULTURE AND COMMUNICATION CASES

Case # 3

Mrs. Yoshida is a 60-year-old Japanese woman whose test results have just shown evidence of advanced stomach cancer. Mrs. Yoshida has been in the U.S. for 10 years and lives with her son and daughter-in-law. Mrs. Yoshida's physician, Dr. Harlan, has just discussed the diagnosis with Mrs. Yoshida's son and his wife. Mr. Yoshida and his wife feel very strongly that Mrs. Yoshida should not be told the diagnosis, as they fear that the word cancer will sound like a death sentence to her and that she will lose hope and get sicker more quickly. They also explain to Dr. Harlan that Mrs. Yoshida will feel that she is placing a great burden on them if she is made aware of her diagnosis. The tradition in Japan is to keep the truth from the patient as long as possible in order to keep her spirits up.

Dr. Harlan understands that the Yoshidas are from a different culture, but she feels both legally and morally obligated to inform Mrs. Yoshida of her diagnosis and to discuss treatment options with her. However, she also wants what is best for the patient, and the son and daughter-in-law are convinced that Mrs. Yoshida would be happier not knowing she has cancer. She feels caught in an ethical dilemma and isn't sure what to do.

Discussion Questions

1. If you were an ethicist assigned to this case, what would you recommend to Dr. Harlan?

2. If you were Dr. Harlan, what would be your next step?

3. What do you think the cultural explanation is for the relative lack of emphasis placed on informed consent in Japan?

4. What about the U.S.? Why do we place such a high value on informed consent and individual responsibility for health care decisions?

Ackerman, 2000.

HANDOUT VC.1.4

CULTURE AND COMMUNICATION CASES

Case # 4

Seema Khan, a twenty-five-year-old Middle Eastern woman, comes into the emergency room with her husband, Ali Khan. Sylvia, the triage nurse, asks Mrs. Khan what problem she is coming in for. Mr. Khan answers that his wife is bleeding and has pain in her lower abdomen. She is four months pregnant.

Sylvia asks Mrs. Khan to change into a patient gown so that the doctor can examine her. Her husband refuses to allow her to change, and angrily says he will not allow a strange man to examine his wife. The attending doctor, who is a man, tries to explain to Mr. Khan that his wife may be having a miscarriage and could bleed to death if she doesn't get medical attention. Mr. Khan becomes angrier and abruptly leaves the hospital with his wife.

Discussion Questions

1. How could the clinicians have handled this situation differently, assuming that the attending was the only doctor available?

2. Do you feel angry at Mr. Khan for his decision? Why?

3. What are some other examples of how gender can have a strong influence on the interaction between patient and clinician?

Ackerman, 2000.

SECTION VI

Eliciting The Patient's Experience of Illness

Introduction

This section focuses on the communication tasks that the clinician and the patient need to accomplish to achieve a successful clinical encounter. For the patient the tasks often include describing his/her health concerns, clarifying the information gleaned in the history and physical, and understanding the clinician's recommendations. For the clinician the tasks include exploring the patient's symptoms, interpreting data, understanding the patient's perspective, and negotiating a treatment plan that allows the patient to integrate the plan into his/her life.

The critical task for both parties is to develop a relationship with the other that allows this flow of information to take place and assures a satisfactory outcome. When the role of culture is not considered in this process, the likelihood of effectively accomplishing these communication tasks can be diminished.

The first exercise highlights the areas of cultural values in which clinicians and patients can differ. After considering some strategies that might help them elicit information from their patients, participants are introduced to several models of cross-cultural communication that outline approaches that the clinician can easily adapt to the clinical interview. The section concludes with the opportunity for the participants to apply the communication models to different clinical simulations.

Learning Objectives

At the conclusion of Section VI the learner will be able to:

1. explain the unique challenges in cross-cultural communication in the clinical setting;
2. list questions that can be helpful in eliciting dimensions of culture;
3. describe four models that can be used to elicit patients' illness experiences and beliefs;
4. apply one or more of the models to common clinical scenarios to elicit patients' experiences and beliefs.

Exercise VIA: What Do We Need to Know about Ourselves to Provide Culturally Competent Care?

TIME: 45 MINUTES

Type of Activity
Discussion

Purpose
To help participants understand their own cultural norms and preferences and to explore strategies for working with patients who have different norms.

Learning Objective
Participants will be able to identify some of their cultural values and describe how they might respond when working with a patient who has different values.

MATERIALS

- Handout VIA.1: Your Cultural Values
- Flipchart / markers

Steps

1. Begin by asking participants: "Which cultural norms have you encountered among different patient populations that have been hard to adapt to (e.g. the man being the primary decision-maker in a family)?" Write responses on the flipchart.

2. Distribute Handout VIA.1 and ask participants to fill it out on their own. Give an example of how to fill it out.

3. When they are finished, have a discussion using the questions listed below. As an alternative exercise, you might want to consider pairing the participants into groups of two and asking them to discuss their responses together. Allow 10 minutes for these conversations and then bring the group back together to ask these questions.

   - Look at your profile. What does this information suggest to you?
   - Describe patients that you have had difficulty communicating with in which differences in these values played a role. Where do you most want to expand your comfort zone?
   - How might you do this?
   - What are the consequences of doing nothing differently?

4. If you have previously used Exercise IIB in your training, you may want to draw a link between the shared content in these two exercises.

5. Transition to the next exercise.

HANDOUT VIA.1

YOUR CULTURAL VALUES

Directions: On each continuum below, place an X indicating where you believe you fall as an individual. Put parentheses around the area on the continuum that reflects your comfort zone when interacting with other people.

SOCIAL STATUS

Inherited . . . . . **Earned**

PRIVACY

Guarded . . . . . **Open/Shared**

FATALISM

Fate determined by outside influence . . . . . **Fate determined by self**

GROUP/INDIVIDUAL

Health care decisions made by family/group . . . . . **Health care decisions made by individual**

ACCESS TO INFORMATION

Information withheld . . . . . **Right to Know**

Adapted from Gardenswartz, 1999.

Exercise VIB: What Do We Need to Know about Patients to Provide Culturally Competent Care?

TIME: 30 MINUTES

Type of Activity
Discussion

MATERIALS

Flipchart/markers

Purpose
To create a framework for eliciting patients' experiences and perceptions of illness.

Learning Objectives
Participants will be able to:
1. identify patient information that can help the clinician provide culturally competent care;
2. articulate critical questions and strategies that can help elicit patient information.

Steps

1. Review the definition of cultural competence. This definition is provided in Section II and should be posted so that it can be easily referred to during the training. Remind participants that the key to culturally competent health care is effective communication that incorporates the patient's point of view into the clinician's explanation and treatment recommendations.

2. Ask participants to describe what they would like to know about their patients in order to provide more culturally competent care (e.g. how she/he perceives his/her illness; the role of the patient's family in health care decision-making). Write responses on the flipchart as they are mentioned.

3. When the list is finished, ask participants to create questions they could ask of patients in order to solicit this information. Write down these questions on a separate sheet.

4. Ask participants to consider other strategies, in addition to the list of questions that might assist them in gathering the information they need. Include these strategies on the list of questions. Keep the questions and strategies posted to refer to in subsequent exercises in this section.

5. Give a brief description of the following cultural dimensions and give specific examples of how each can manifest in different contexts. Some of these dimensions were described in Section II. Be sure to acknowledge that you are using *generalizations* for the purposes of this discussion. Ask participants if there is anything else they want to add to the list of questions and strategies that they created in the prior step.

   - **Social Status** - How decisions are made about treatment and who is involved in decisions can be determined by status. In some cultures, status is inherited. In others, status is earned. *Example:* A physician approaches her elderly Pakistani patient about the need to consider a hysterectomy. The patient's husband insists that all questions be directed to him.

   - **Privacy** - A value on personal privacy may make it harder to obtain information. Relationship building is key and gaining insight from interpreters who can also serve as cultural brokers can be helpful. *Example:* When asked by her new clinician about depression following her husband's death the monolingual Chinese woman smiles and reassures him that everything is fine.

   - **Fatalism** - To people who are fatalists, a disease or condition may be perceived as " meant to be" or "God's will." This may shape attitudes toward treatment and intervention on one's own behalf. You may need to consider the value of prayer and the assistance of a spiritual leader. *Example:* An El Salvadoran man diagnosed with metastatic colon cancer refuses treatment, insisting that there is nothing else to be done.

   - **Individual control vs. group control** - For people who rely on the "group" (family, extended family, clan, etc.) for support, health decisions may not be made by the individual. In this case, the patient cannot be considered in isolation. *Example:* A Thai woman insists that her physician discuss her diagnosis of appendicitis with her family before she consents to surgery.

- **Right to know** - People from some cultures may believe in withholding information from the patient, particularly when there is a terminal diagnosis. Learn as much as you can about the patient and his/her family before telling all and take into account perceptions of the illness and the stigma or meaning attached to it. *Example:* The family of a Japanese patient insists that their father not be told that he has been diagnosed with gastric cancer.

6. Leave the lists on the wall for the rest of the section and encourage participants to change or add to the lists during the following exercises.

7. Transition to the next exercise.

TIME: 45 MINUTES

Exercise VIC: Models to Elicit The Patient's Illness Experience and Beliefs

MATERIALS

Overhead VIC.1: Eliciting the Patient's Explanatory Model: Kleinman's Questions

Overhead VIC.2: The Patient-Centered Clinical Method

Overhead VIC.3: The Patient-Centered Clinical Method (Conceptual Model)

Overhead VIC.4: The LEARN Model

Overhead VIC.5: The RESPECT Model

Type of Activity

Lecture/Discussion

Purpose

To provide participants with several models for eliciting patients' explanatory framework and to compare and contrast these models with the questions developed by participants in Exercise VIB.

Learning Objective

Participants will be able to explain several models for eliciting patients' illness experience and beliefs and apply them to clinical situations.

In Preparation

A number of communication models are presented in this exercise. To avoid confusing the participants, you might want to limit the number of models you present or, as an alternative, you might divide this exercise into two components. In addition, it is often helpful to distribute handouts of these overheads.

When working with Overhead VIC.1 consider highlighting how these questions can be applied to a specific clinical situation. The book, "The Spirit Catches You and You Fall Down" by Anne Fadiman, has an example (pp 260-1) of how effective this model can be in a clinical encounter.

Steps

1. Explain that you will present several different models for eliciting patients' experiences and beliefs about their illness. During this exercise, ask participants to point out similarities and differences among the models. Ask how these models compare to the questions the group generated in Exercise VIB.

2. Present Overhead VIC.1. Review the questions with the group. Discuss strategies for working with patients who are uncomfortable answering such direct questions about their beliefs.

3. Present Overhead VIC.2. Ask the group to develop appropriate questions that reflect these four concepts. Compare these questions to the ones developed in Exercise VIB.

4. Present Overhead VIC.3. Explain that the left side of the overhead outlines the traditional approach to evaluating and treating a patient. The right side incorporates the patient's thoughts and experiences with the disease or illness. The Patient-Centered Clinical Method suggest how it is possible to integrate these approaches in a clinical encounter in order to achieve an integrated understanding and create an appropriate management plan.

5. Present Overhead VIC.4. Ask participants to consider if this model is helpful. What might be missing from this approach?

6. Present Overhead VIC.5. Ask participants to compare this with the other models that have been discussed. What are the advantages? What are the disadvantages?

7. Discuss with participants the usefulness of these four models. Discuss similarities and differences between the models as weli as with the participant-generated questions from Exercise VIB.

8. Transition to the next exercise in which the participants will apply these models to clinical situations.

OVERHEAD VIC.1

ELICITING THE PATIENT'S EXPLANATORY MODEL:
Kleinman's Questions*

1. What do you call the problem?

2. What do you think has caused the problem?

3. Why do you think it started when it did?

4. What do you think your sickness does? How does it work?

5. How severe is the sickness? Will it have a short or long course?

6. What kind of treatment do you think you should receive?

7. What are the most important results you hope to receive from this treatment?

8. What are the chief problems the sickness has caused?

9. What do you fear most about the sickness?

* Kleinman, 1978.

OVERHEAD VIC.2

PATIENT-CENTERED CLINICAL METHOD

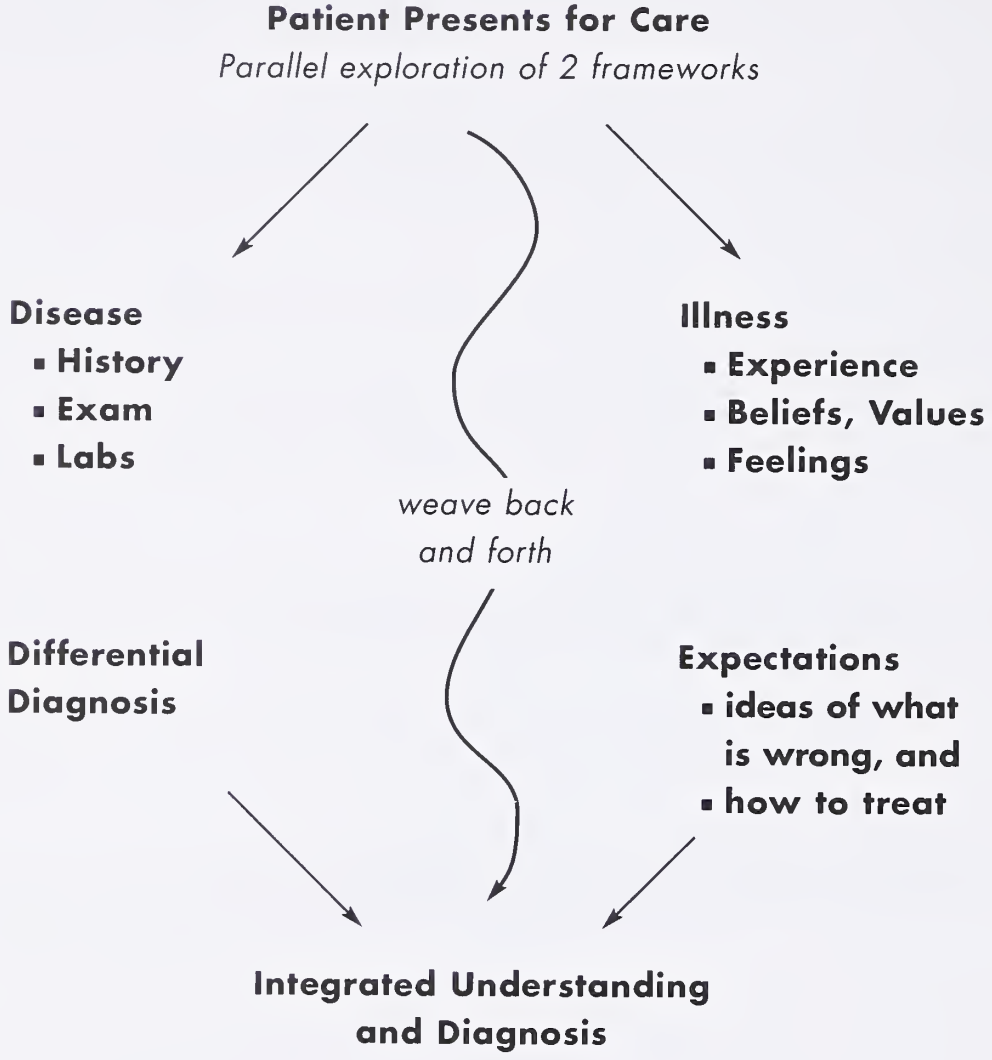
This approach focuses on disease and four dimensions of patients' illness experiences. Clinical questions are designed to elicit information from patients about:

- **Their ideas about what is wrong with them.**
- **Their feelings, especially fears, about being ill.**
- **The impact of their problems on functioning.**
- **Their expectations about what should be done.**

Adapted from Stewart, 1995.

OVERHEAD VIC.3

PATIENT-CENTERED CLINICAL METHOD (Conceptual)



Adapted from Stewart, 1995.

OVERHEAD VIC.4

The LEARN Model*

L Listen with sympathy and understanding to the patient's perception of the problem.

E Explain your perceptions of the problem.

A Acknowledge and discuss the differences and similarities.

R Recommend treatment.

N Negotiate agreement.

* Berlin, 1983.

OVERHEAD VIC.5

The RESPECT Model*

Rapport
- Connect on a social level.
- See the patient's point of view.
- Consciously attempt to suspend judgement.
- Recognize and avoid making assumptions.

Empathy
- Remember that the patient has come to you for help.
- Seek out and understand the patient's rationale for his/her behaviors or illness.
- Verbally acknowledge and legitimize the patient's feelings.

Support
- Ask about and try to understand barriers to care and compliance.
- Help the patient overcome barriers.
- Involve family members if appropriate.
- Reassure the patient you are and will be available to help.

Partnership
- Be flexible with regard to issues of control.
- Negotiate roles when necessary.
- Stress that you will be working together to address medical problems.

Explanations
- Check often for understanding.
- Use verbal clarification techniques.

Cultural Competence
- Respect the patient and his/her culture and beliefs.
- Understand that the patient's view of you may be defined by ethnic or cultural stereotypes.
- Be aware of your own biases and preconceptions.
- Know your limitations in addressing medical issues across cultures.
- Understand your personal style and recognize when it may not be working with a given patient.

Trust
- Self-disclosure may be an issue for some patients who are not accustomed to Western medical approaches.
- Take the necessary time and consciously work to establish trust.

*Source Unknown.

Exercise VID: Applying Models to Elicit the Patient's Illness Experience and Beliefs

TIME: 60 MINUTES

Type of Activity
Clinical Simulations/Discussion

Purpose
To provide participants with an opportunity to practice eliciting a patient's illness experience and beliefs using the models presented in Exercise VIC.

Learning Objective
Participants will be able to apply one or more models to improve interview techniques for eliciting patients' illness experience and beliefs.

In Preparation
Each simulation has three roles. Before starting this exercise, put the simulation roles in separate envelopes and label the envelopes with the simulation number and the role. Participants should view only their role. Be sure to plan sufficient time for this exercise so that participants have the chance to play each of the three roles.

MATERIALS

Handout VID.1.1–VID.1.9: Simulation

Steps

1. Divide participants into groups of three and give each group a simulation with three roles: patient, clinician, or observer. Explain that the observer will not participate, but will offer feedback and suggestions afterwards. Each simulation will last approximately 10 minutes, including feedback and each group will have time for three simulations so that each participant has a chance to play each role. Make sure that enough time is reserved for debriefing the simulations. The participants should not look at each other's role descriptions.

2. Explain that the person who plays the clinician should choose one of the communication models that were discussed in Exercise VIC and apply it to the simulation.

3. Tell participants that you will signal them after five minutes to end the simulation and move on to feedback. After a few minutes of feedback, signal them again to move on to the next simulation. Be sure that the roles are changed for each of the simulations so that everyone has the chance to play the three roles.

4. After each group has finished all three simulations, bring participants back to the large group and ask the following questions.

   - What did it feel like to do the simulations?
   - Which role did you feel most comfortable in? Why?
   - Which model did you find the most useful for eliciting the patients' illness experience and beliefs?
   - What difficulties did you experience in using the models?
   - What other questions were effective in eliciting critical patient information? (Add these questions to the list from Exercise VIB.)
   - How did your own cultural orientation influence your reactions and difficulties?

5. Transition to the next exercise.

HANDOUT VID.1.1

SIMULATION 1: HERBAL MEDICINE

1. **You are the clinician.** Your patient is a 65-year-old woman from China named Mrs. Pao. She is presented to the ER with a painful, swollen left leg and was found to have a thrombus in the deep femoral vein of her left leg. Mrs. Pao was hospitalized previously for proximal deep vein thrombosis (DVT) complicated by pulmonary embolism (PE). She has been taking warfarin since her first DVT. You learn from her chart that she was on estrogen treatment for her osteoporosis until the time of her PE. You find it odd that even on medications for anticoagulation, Mrs. Pao presented with recurrent thrombosis. *Hints*: 1) Fung Sui Ging is a Chinese word for rheumatism. 2) Certain brands of Ginseng tea are known to increase the level of estrogen in the body.

2. **You are the patient.** Your name is Mrs. Pao. You were born in China and are 65 years old. You were in the hospital several months ago for a blood clot. Since that time, the doctors asked you to stop taking estrogen for your osteoporosis and instead asked you to take a medication called Warfarin. You're not sure if the western doctors are helping you, so recently you've also been seeing a traditional doctor in Chinatown. He has been giving you a Ginseng tea, which helps with your Fung Sui Ging (wind wetness). You trust the Chinese doctor and feel that he has been helping you a lot. However, you have been having a lot of pain in your left leg recently, so you decided to come to the hospital today.

3. **You are the observer.** Your job is to observe the interaction between the patient and the clinician and to offer feedback and suggestions afterwards. As you watch the role play, keep in mind the following questions:

   - What differences do you see between the patient and the clinician?
   - What are these differences based on — culture, communication style, etc.?
   - How well is the clinician dealing with these differences? Is s/he being sensitive to the patient's concern, beliefs, etc.?
   - Do you have any suggestions for the clinician to help him/her work more effectively with this patient?

Adapted from Ackerman, 2000.

HANDOUT VID.1.2

SIMULATION 2: HERBAL MEDICINE

1. **You are the clinician.** You are a primary care clinician and you are seeing Mr. Ian Reid, a Scottish man, who has been living in the U.S. for the past 10 years. He was recently diagnosed with Hepatitis C during a screening exam for a volunteer position at a health clinic. He comes in for an office visit to talk about his diagnosis and wants to discuss your recommendations about his use of milk thistle, turmeric, St. John's wort and LiverAid to improve the health of his liver. You are concerned about the possible impurity of the herbal remedies and the effects of the combination of herbal agents on his liver. *Hint*: You are aware of a recent article (Jacobson JM, Feinman L, Liebes L, et al. Pharmacokinetics, safety, and antiviral effects of hypericin, a derivative of St. John's wort plant, in patients with chronic Hepatitis C virus infection. Antimicrob Agents Chemother 2001 Feb;45(2):517-24.) which suggests that St John's wort can cause sun sensitivity and does not decrease the level of the hepatitis virus in the body.

2. **You are the patient.** Your name is Mr. Ian Reid and you immigrated to the U.S. from Scotland 10 years ago. You were recently diagnosed with Hepatitis C while being screened for a volunteer position at a local health clinic. Since that time, you have been feeling overwhelmed and are trying to learn as much as you can about this illness. You believe strongly in blending eastern and western approaches to health care and are interested in first using natural approaches to treat this problem. You are currently using milk thistle, turmeric, St. John's wort and LiverAid to improve the health of your liver. You trust the advice of your acupuncturist and herbalist and feel that they have been helping you a lot. You have also decided to see your primary care clinician to make sure that you are doing everything that you can to stay healthy.

3. **You are the observer.** Your job is to observe the interaction between the patient and the clinician and to offer feedback and suggestions afterwards. As you watch the role play, keep in mind the following questions:

   - What differences do you see between the patient and the clinician?
   - What are these differences based on — culture, communication style, etc.?
   - How well is the clinician dealing with these differences? Is s/he being sensitive to the patient's concern, beliefs, etc.?
   - Do you have any suggestions for the clinician to help him/her work more effectively with this patient?

Developed by Sunita Mutha, UCSF Center for the Health Professions.

HANDOUT VID.1.3

SIMULATION 3: DIFFERENT BELIEFS

1. **You are the clinician.** Your patient is a West African woman named Angelique Kasse who is having difficulty progressing through labor. An external monitor is showing signs of fetal distress and you feel strongly that the woman should opt for a Cesarean section. If she refuses, you're concerned that she will be endangering the life of her baby.

2. **You are the patient.** Your name is Angelique Kasse and you are from Senegal (West Africa). You are about to give birth to your second child. You are having difficulty with this labor and the doctor wants you to have a Cesarean section. However, you are strongly against having a c-section and you refuse to consent to one. In your view, facilities for repeat c-sections will not be available when you return to Africa and it is very important to you to be able to continue to have children. You are willing to sacrifice the life of this child to ensure that you can have children in the future. In addition, you believe that each baby exists as a spirit before it is born and that a pregnancy is a way for the spirit to find out if it wants to be born as a human being. It might decide that the conditions are not right and it will try again another time. You will accept the outcome no matter what and you don't want a doctor interfering with your beliefs or your experience of childbirth.

3. **You are the observer.** Your job is to observe the interaction between the patient and the clinician and to offer feedback and suggestions afterwards. As you watch the role play, keep in mind the following questions:

   - What differences do you see between the patient and the clinician?
   - What are these differences based on — culture, communication style, etc.?
   - How well is the clinician dealing with these differences?
   - Is s/he being sensitive to the patient's concerns, beliefs, etc.?
   - Do you have any suggestions for the clinician to help him/her work more effectively with this patient?

Ackerman, 2000.

HANDOUT VID.1.4

SIMULATION 4: DIFFERENT BELIEFS

1. **You are the clinician.** Your patient is an East Indian woman, Sarojben Amin, who you are seeing for an annual visit. She arrives for the visit with her husband. You explain that you will need to perform breast and pelvic exams today. You are very concerned about her strong family history of breast and ovarian cancer (her mother and one sister died of breast cancer and another sister died of ovarian cancer). She refuses to undergo this part of the exam.

2. **You are the patient.** Your name is Sarojben Amin and you are an East Indian woman who is feeling well. You have come to the office today because your son said that you should have a physical exam. The nurse practitioner tells you that you should have a breast and pelvic exam done during this visit. You don't understand the need for these parts of the exam since you have finished having children and are not sexually active. You will not make this decision without your husband's approval. For the sake of privacy while the clinician is in the room, you speak with your husband in your native language, Gujarati, and ask him what he thinks. He agrees with you that it not necessary.

3. **You are the observer.** Your job is to observe the interaction between the patient and the clinician and to offer feedback and suggestions afterwards. As you watch the role play, keep in mind the following questions:

   - What differences do you see between the patient and the clinician?
   - What are these differences based on — culture, communication style, etc.?
   - How well is the clinician dealing with these differences?
   - Is s/he being sensitive to the patient's concerns, beliefs, etc.?
   - Do you have any suggestions for the clinician to help him/her work more effectively with this patient?

Developed by Sunita Mutha, UCSF Center for the Health Professions.

HANDOUT VID.1.5

SIMULATION 5: TRADITIONAL HEALERS

1. **You are the clinician.** You are seeing Maria Mendez for the first time. She is from Mexico and has been in the United States for two years. Ms. Mendez has been on heart medication for a year but she is still experiencing chest pain and fatigue. This is why she is here to see you today.

2. **You are the patient.** Your name is Maria Mendez. You are originally from Mexico and have lived in the U.S. for about two years. A year ago a doctor prescribed some medicine for your pain and you take it sometimes, but are not sure how much it has helped. You feel that your pain might be caused by the spirit of your ancestors who are angry at you for leaving Mexico. Recently you visited a curandera and she performed a ritual and gave you some herbs to take and these seemed to help. Still, you think the doctor may be able to help you as well. You are not sure if you should talk to the doctor about the herbs and the curandera, as doctors in the past have seemed to disapprove when you told them about this.

3. **You are the observer.** Your job is to observe the interaction between the patient and the clinician and to offer feedback and suggestions afterwards. As you watch the role play, keep in mind the following questions:

   - What differences do you see between the patient and the clinician?
   - What are these differences based on — culture, communication style, etc.?
   - How well is the clinician dealing with these differences?
   - Is s/he being sensitive to the patient's concerns, beliefs, etc.?
   - Do you have any suggestions for the clinician to help him/her work more effectively with this patient?

Welch, 1999.

HANDOUT VID.1.6

SIMULATION 6: TRADITIONAL HEALERS

1. **You are the clinician.** You are seeing a new patient, Jonathan Brier, who is complaining of decreased appetite, fullness after eating very small meals, weight loss, and abdominal pain for the past 3 months. In the last two weeks he has noticed that his eyes seem jaundiced. You are very concerned that he has cancer.

2. **You are the patient.** Your name is Jonathan Brier. You have decided to seek medical care for decreased appetite, fullness after eating very small meals, weight loss and abdominal pain for the past 3 months. In the last two weeks you have also noticed that your eyes seem yellow. You are very worried about these symptoms. You are a devoted practitioner of Tibetan Buddhism and believe that healing practices such as pujas can help your symptoms. You have had two pujas performed on your behalf. You have also been taking herbal remedies for the past month given to you by a traditional healer who successfully treated your back pain. Your doctors at the time were telling you that you would not improve without surgery. You would like to find a way to address your current health problems that are aligned with your beliefs.

3. **You are the observer.** Your job is to observe the interaction between the patient and the clinician and to offer feedback and suggestions afterwards. As you watch the role play, keep in mind the following questions:

   - What differences do you see between the patient and the clinician?
   - What are these differences based on — culture, communication style, etc.?
   - How well is the clinician dealing with these differences?
   - Is s/he being sensitive to the patient's concerns, beliefs, etc.?
   - Do you have any suggestions for the clinician to help him/her work more effectively with this patient?

Developed by Sunita Mutha, UCSF Center for the Health Professions.

HANDOUT VID.1.7

SIMULATION 7: TRADITIONAL HEALERS

1. **You are the clinician.** You are seeing Erik Gbodossou, a 38 year-old West African man, who is HIV infected and is hospitalized with pneumonia. He has improved clinically since being admitted to the hospital. He is willing to take the antibiotics prescribed for his pneumonia, but is balking at taking antiretroviral therapy which you know may help improve his life expectancy. You have specialized in care for HIV infected patients and are frustrated that this patient is not interested in treatment that can help him. You've checked and his insurance will pay for most of the cost of his medications.

2. **You are the patient.** You are a 38-year-old man named Erik Gbodossou. You are originally from West Africa. You are in the hospital and being treated for pneumonia. You feel much better than when you first came to the hospital. You found out 2 years ago that you are infected with the AIDS virus. You have been seeing a traditional healer who is well respected in your community. He has successfully treated you for diarrhea and skin problems in the last 6 months by mixing special medicines for you. Using divining bones, the healer has helped you understand that your illness has happened in part because you have been distant from your family and community since leaving Senegal. Now, this doctor in the hospital is telling you that you must take western medicines to keep your HIV infection from getting much worse. You're not convinced that this is the right thing to do. You want to talk this over with the healer.

3. **You are the observer.** Your job is to observe the interaction between the patient and the clinician and to offer feedback and suggestions afterwards. As you watch the role play, keep in mind the following questions:

   - What differences do you see between the patient and the clinician?
   - What are these differences based on culture, communication style, etc.?
   - How well is the clinician dealing with these differences?
   - Is s/he being sensitive to the patient's concerns, beliefs, etc.?
   - Do you have any suggestions for the clinician to help him/her work more effectively with this patient?

Developed by Sunita Mutha, UCSF Center for the Health Professions.

HANDOUT VID.1.8

SIMULATION 8: DIFFERENT BELIEFS

1. **You are the clinician.** Your patient is a 9-month old white male who was recently diagnosed with a severe sensory-neural hearing loss (nerve deafness). The patient (Freddy Samuels) has two older siblings (ages 4 and 7) who are profoundly deaf, as are the parents and grandparents. You and all of the other professionals believe that Freddy should receive hearing aids for both ears immediately to maximize the chances for optimal speech and language development. You know that the critical window for speech and language development is rapidly closing, and that if he does not receive amplification soon, he will be forced to rely on sign language as his primary mode of communication for the rest of his life. The parents are refusing hearing aids, stating that they do not wish to raise the child in the hearing world.

2. **You are the patient.** You are Mr. Samuels, parent of 9-month old Freddy. You and your wife have both been deaf your entire lives. You communicate primarily using sign language, but are able to read lips well enough to get by minimally in the hearing world. You have two deaf children who also communicate in sign language which is the primary language in your home. Your pediatrician and audiologist have just informed you that Freddy is severely hearing impaired, but not as deaf as you or your other children. They believe that Freddy should have hearing aids so that he may develop speech and language normally. You want to raise him in the deaf community, as you were raised and as your other children are being raised. The doctors are so insistent that they have implied that they could contact child protective services if you do not comply with their recommendation.

3. **You are the observer.** Your job is to observe the interaction between the patient's parent and the clinician and to offer feedback and suggestions afterwards. As you watch the role play, keep in mind the following questions:

   - What differences do you see between the parent and the clinician?
   - What are these differences based on — culture, communication style, etc.?
   - How well is the clinician dealing with these differences?
   - Is s/he being sensitive to the patient's parent's concerns, beliefs, etc.?
   - Do you have any suggestions for the clinician to help him/her work more effectively with this parent?

Developed by Kenneth Wolf, Charles R. Drew University.

HANDOUT VID.1.9

SIMULATION 9: DIFFERENT BELIEFS

1. **You are the clinician.** You are seeing a new patient, a 14-year-old girl named Eliza Painter, who is coming in for a physical exam for her swim club. You note that she is 5'4" and weighs 100 pounds. She had previously been hospitalized for dehydration and reports that she has had amenorrhea (no menses) for the past year. Your are concerned that she has female athlete triad (amenorrhea, osteoporosis and disordered eating) and your message to her today is going to be that she needs to increase her body weight to resume her menses because she is at very high risk for osteoporosis.

2. **You are the patient.** You are 14-year-old Eliza Painter. In the last two years you have been described as an upcoming swimming superstar with Olympic potential in the 100-meter butterfly. Your coach has been pushing you hard during workouts and told you that you had to lose weight if you were serious about competing at an international level. It's been hard, but you've managed to lose 15 pounds in the past year and your times have been better than ever. You're more determined than ever to "go for the gold." You're a little worried about not having your periods, but know that this is not unusual for women athletes.

3. **You are the observer.** Your job is to observe the interaction between the patient and the clinician and to offer feedback and suggestions afterwards. As you watch the role play, keep in mind the following questions:

   - What differences do you see between the patient and the clinician?
   - What are these differences based on — culture, communication style, etc.?
   - How well is the clinician dealing with these differences?
   - Is s/he being sensitive to the patient's concerns, beliefs, etc.?
   - Do you have any suggestions for the clinician to help him/her work more effectively with this patient?

Developed by Sunita Mutha, USCF Center for the Health Professions.

TIME: 60 MINUTES

Exercise VIE: Our Patients' Stories

Type of Activity
Panel discussion

Purpose
To help participants gain a deeper appreciation of patients' experiences by using a panel of patients to share their stories, answer questions and offer suggestions and advice to the participants about working more effectively with culturally diverse patients.

Learning Objective
Participants will be able to articulate the experiences of patients and their recommendations about how to provide culturally sensitive care.

In Preparation
Recruit four or five people willing to speak about their experiences as a patient. Try to ensure that the group is diverse in terms of ethnicity, age, gender and health beliefs. Panelists should have the following qualities: be comfortable speaking in front of a large group; be articulate; be willing to speak about both good experiences and bad; be aware of how cultural differences can influence the patient-clinician interaction.

Before the training, meet with the panelists and explain what will be expected of them. Cover the following:

- **Ground rules:** Panelists should try to give each other equal speaking time. They are not required to answer questions, and may ask to be skipped if they prefer not to answer a particular question.

- **Questions:** Give the panelists a list of the questions they will be asked. The following questions can be used as a guide, although you may want to change some of the terminology to make the questions applicable to the panelists' experience.

- Are there differences in what you value in your health care versus what your clinician values, or thinks is important?

- Why are some patients reluctant to share information about traditional beliefs or healing practices with their clinician?

- Tell us about a personal experience you have had where cultural beliefs or values made it difficult for you to communicate with your clinician.

- If you could change something about the way clinicians interact with their patients, what would you change?

Steps

1. Introduce the panelists and explain to the participants the following procedures for the panel discussion. Panelists will be asked several previously identified questions. This will take approximately 30 minutes. In the time remaining, participants will be free to ask their own questions of the panelists. Explain that participants are encouraged to ask any question they want, but that panelists have the right to decline to answer a question.

2. Pose the first question to the panelists. Moderate the discussion by making sure that the more vocal panelists do not prevent other panelists from speaking. Using the four questions listed above, the panel will have approximately 7–8 minutes to answer each question.

3. Try to save at least 15 minutes for questions from participants.

4. At the end of the discussion, thank the panelists for generously sharing their time and experiences with the participants.

5. Transition to the next exercise.

SECTION VII

The Role of the Medical Interpreter

Introduction

In Section VII we continue to look at communication in the clinician-patient relationship by focusing on encounters where language is a barrier. The most recent U.S. census shows that foreign-born residents now account for 11% of the population. In addition, 17% of the U.S. population speaks a language other than English at home and only 23% of these individuals report speaking English "very well." (See Section III for additional details.) It is known that language skills are closely associated with educational attainment, access to care and health outcomes. Thus, language has a very central role in all aspects of health care and using medical interpreters may reduce disparities in health outcomes.

As noted in the discussion of the CLAS Standards (see Section III), the Federal government has placed significant emphasis on equalizing access to health care by establishing language guidelines for health care facilities. The effective use of medical interpreters is the focus for this section.

We begin by simulating the interpreter experience for participants to help them understand the roles and responsibilities of an interpreter. We then use a videotape to demonstrate the differences in encounters between untrained and highly trained interpreters. The exercises provide pragmatic information to guide clinicians in working more effectively in situations when they do not have access to trained interpreters.

Learning Objectives

At the conclusion of Section VII the learner will be able to:

1. describe the characteristics of a skillful interpreter;
2. explain the reasons for using interpretation services to improve health outcomes;
3. choose an appropriate interpreter;
4. demonstrate how to work with an interpreter;
5. conduct a clinical interview using an untrained interpreter.

Exercise VIIA: The Experience of an Interpreter

TIME: 30 MINUTES

Type of Activity
Simulation/Discussion

Purpose
To give participants an opportunity to directly experience the skills required for effective interpretation.

Learning Objective
Participants will be able to describe some of the listening and memory skills needed for effective interpretation.

MATERIALS

- **Handout VIIA.1: Radiotelephone**
- **Flipchart/markers**

Steps

1. Ask participants to divide into pairs for this activity and distribute one copy of the handout to each pair. One participant will read out loud from the handout and the other will act as the interpreter by repeating what s/he hears.

2. Instruct the reader to stop after reading the first sentence out loud. The interpreter should then repeat the sentence verbatim. Once the interpreter has repeated the full sentence successfully, the reader begins again with the first sentence and adds the next sentence. The interpreter must be able to repeat both sentences verbatim before both can proceed to add additional sentences in the phrase.

3. Have participants switch roles after 3–4 minutes of this activity.

4. After each has had the chance to serve as an interpreter, have participants discuss and record the following:

   - What did it feel like?

   - What was difficult about the experience of acting as an interpreter?

5. Reconvene the participants to a large group discussion. List the two questions above on a flip chart. Ask the participants to share what they discussed in their small groups. You may choose to write their comments on the flip chart and then summarize by identifying the themes raised in their discussions (e.g., difficulty with unfamiliar language, complexity of content, etc.). Be sure to help the group see that the issues they identified are parallel to those experienced by medical interpreters (complex content, unfamiliar and highly technical words or phrases).

6. Ask the group to discuss how well they think this activity reflects their experiences working with medical interpreters. Explain that using short sentences is a helpful technique for conveying complex information and enhancing a medical interpreter's ability to accurately interpret the conversation for a patient.

7. Transition to the next exercise.

HANDOUT VIIA.1

RADIOTELEPHONE EXERCISE

Instructions:

Do this exercise in pairs. Choose one person to be the reader and one to be the listener. The reader will read sentence #1 and pause to let the listener repeat the sentence. The reader will then correct any errors and the listener must repeat the entire sentence verbatim in order to be able to go to the next step. For the next step, the reader will read both sentences 1 and 2. Again, the reader will pause to let the listener repeat those sentences, then correct any errors and proceed only when the listener can repeat the sentences verbatim. Continue this way to the end of the exercise.

1. Listen carefully to these instructions.

2. Your radiotelephone is vital for emergency communications. Set the squelch so you can understand distant signals.

3. In an emergency, always use Channel 16. It has a frequency of 156,800 MHz for sending and receiving. The SSB distress and calling frequency is 2182 kHz. There are three spoken emergency signals that show the degree of severity of the emergency, mayday, pan and security pronounced say-cur-ee-tay.

4. Before sending a distress signal, send a Radiotelephone Alarm Signal that sends two audio frequency tones similar to the two-tone siren used by ambulances. When you send a distress signal and message on Channel 16, do not switch to another channel because you may lose radio contact. State the position of your vessel either by latitude of longitude or by a bearing and a distance from a well-known landmark. The EPIRB emits a continuous radio signal alerting authorities to the existence of the distress situation. You can initiate a VDS alert for the search and rescue team.

Adapted with permission from an exercise created by Marilyn Mochel, Healthy House, California Healthcare Collaborative.

TIME: 1½ TO 2 HOURS

Exercise VIIB: Working with Medical Interpreters

MATERIALS

- Flipchart / markers
- Overhead VIIB.1: Why Use an Interpreter?
- Overhead VIIB.2: How Interpreters Could Reduce Disparities
- Overhead VIIB.3: Choosing an Interpreter
- Overhead VIIB.4: Working with an Interpreter
- Videotape: Communicating Effectively through an Interpreter

Type of Activity

Lecture / videotape / discussion

Purpose

To give participants information about how to work with a medical interpreter and to have a hands-on experience analyzing a patient-clinician-interpreter interaction.

Learning Objectives

Participants will be able to:

1. identify key characteristics of an effective medical interpreter;
2. list techniques a clinician can use to improve the patient-clinician-interpreter interaction.

Steps

1. Discuss Overhead VIIB.1 using the following guidelines:

   - Ask participants to think about the best care they can provide a patient, and ask them to estimate what percentage of this care they would be able to provide if there were a language barrier between them and their patients. When they have shared their guesses with you, go on to ask them how this would affect long-term health outcomes.

   - Briefly discuss the legal ramifications of not providing adequate medical interpretation. Title VI of the Civil Rights Act of 1964 states that "no person in the United States shall on the ground of race, color or national origin, be excluded from participation in, be denied the benefits of, be subjected to discrimination under any program or activity receiving Federal financial assistance." In order to comply with Title VI, therefore, health care clinicians must address the language assistance needs of their patient populations.

   - Briefly address the recently published CLAS Standards, which specify the need for linguistically appropriate services. (See Handout IIIC.2.)

   - Mention that while the cost of medical interpreters may be high, it is likely to be far less costly in the long run than delayed care, or lawsuits resulting from misdiagnosis, etc., that can occur in a setting with language barriers.

2. Review Overhead VIIB.2. This model has been proposed as a way in which use of medical interpreters can improve health care and health outcomes and reduce health disparities.

3. Review Overhead VIIB.3. Acknowledge to participants that they as individuals may not have the power to determine that each of these criteria are met by their facility, but that appropriate care can only be provided if they *are* met.

4. Show the video, starting with the vignette of an ineffective interpreter. The vignette is not at the beginning of the tape, therefore you will have to forward the tape to the correct starting point before the training. Stop the video at the end of the vignette; the video will have the words "Stop the tape for discussion."

5. Ask participants to brainstorm about what went wrong in the interview, and record their ideas on the flipchart. You may want to pose this by asking them 1) what they *wish* they would have seen happen in this scenario and 2) what were the *pluses* (what did the interpreter do well) in the scenario? Then show the video's analysis of the interview (shown after the vignette), and compare with participants' ideas.

6. Show the second vignette, which portrays an effective interpreter. Stop the video at the end of the vignette and discuss with participants what was done differently in this interaction. As in the first vignette, write participants' ideas on the flipchart and then view the discussion section on the video.

7. Show the third vignette, which portrays a physician effectively working with an untrained interpreter.

8. Discuss with participants their personal experiences in working with interpreters and what they will do differently after this exercise.

9. Use Overhead VIIB.4 to reiterate the key points that were discussed after viewing the video.

10. Transition to the next exercise.

OVERHEAD VIIB.1

WHY USE AN INTERPRETER?

1. Improve quality of care

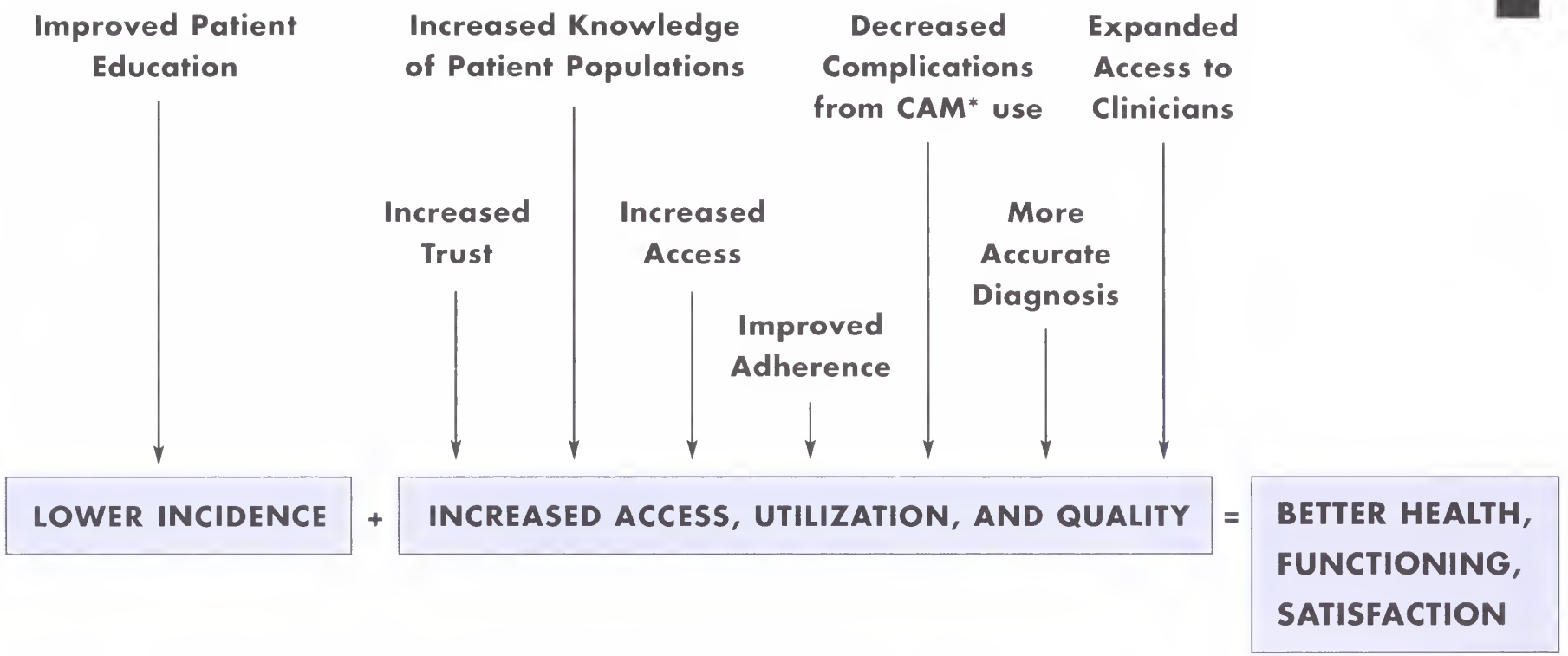
2. Better health outcomes

3. Legal ramifications (Title VI of the Civil Rights Act)

4. Culturally and Linguistically Appropriate Services Standards (CLAS Standards)

5. Health care costs

HOW INTERPRETERS COULD REDUCE DISPARITIES



*CAM = Complementary and alternative medicine

Adapted from Brach, 2000.

OVERHEAD VIIB.3

CHOOSING AN INTERPRETER

1. Use a professionally trained medical interpreter.

2. Avoid using personnel who are bilingual if they have not had training as an interpreter.

3. Avoid using family members as interpreters, especially those of a different age or gender from the patient.

4. Be sensitive to the patient's right to privacy and their choice of who should act as an interpreter. Problems may arise when the interpreter is of the same social group, different social class, educational level, age or gender.

OVERHEAD VIIB.4

WORKING WITH AN INTERPRETER

1. Encourage the interpreter to meet with the patient before the interview; when possible, meet with the interpreter yourself ahead of time in order to:
   - Ask the interpreter to provide feedback.
   - Tell the interpreter where you want him/her to sit.
   - Establish the context and nature of the visit.
   - Ask the interpreter if s/he has any concerns to share with you before the visit.
2. Introduce the interpreter formally at the beginning of the interview.
3. Direct questions to the patient, not to the interpreter, unless they are meant for the interpreter.
4. Avoid technical terms, abbreviations, professional jargon and idioms.
5. Encourage the interpreter to repeat verbatim the patient's own words rather than paraphrasing or omitting information.
6. To check the patient's understanding and accuracy of the interpretation, ask the patient to repeat instructions/advice in their own words, with the interpreter facilitating.
7. Watch the patient's nonverbal communication.
8. Be patient. An interpreted interview takes longer.

SECTION VIII

Culture in the Workplace

Introduction

This section highlights specific issues in which cultural differences can play an important role in shaping interpersonal relationships in the workplace as well as the delivery of health care. We begin by looking at how health care teams function and give participants an opportunity to consider cultural influences in interpersonal and group interactions. Exercises on consensus building and conflict management are included to highlight how individual attitudes and values can affect team function.

The focus is then directed toward cross-cultural conflict resolution and attention is given to cultural norms as they present in workplace behaviors. Because misunderstandings can arise when behaviors are misinterpreted, we focus on identifying how cultural norms can lead to conflict and describe strategies that can help resolve conflict. The section concludes with a discussion on collusion in the workplace and strategies for dealing with incidents involving stereotypes and discrimination.

Learning Objectives

At the conclusion of Section VIII the learner will be able to:

1. identify ways in which cultural differences can affect interactions within health care teams;
2. list behaviors that encourage and discourage consensus building in group settings;
3. describe how culturally-based values can affect group dynamics;
4. identify ways in which cultural differences can lead to interpersonal conflict;
5. list techniques for resolving conflict in culturally sensitive ways;
6. demonstrate strategies for avoiding colluding with inappropriate behavior or offensive remarks in the work setting.

Exercise VIIIA: Cultural Differences and the Health Care Team — TIME: 60 MINUTES

Type of Activity
Discussion

Purpose
To provide participants the opportunity to share their experiences and consider how cultural differences affect health care teams across professional hierarchies.

Learning Objective
Participants will be able to identify the ways in which cultural differences can affect interactions among staff and colleagues in health care settings.

In Preparation
This exercise asks participants to write about a personal experience involving an interaction with a colleague. If you are in touch with participants in advance, you may consider asking participants to do this step as homework prior to this session. Step 1 includes instructions and questions to be answered. Be sure to save these vignettes as they will be referred to again in Exercises VIIID and VIIIE.

MATERIALS

- Flipchart / markers
- Paper and pens

Steps

1. Hand out paper and pens to each participant. Ask them to think about their experience working with a colleague who is culturally different from them. Remind the group that cultural differences can be due to differences in values and beliefs that are linked to dimensions such as race, gender, ethnicity, class, sexual preference, and physical ability.

   Ask them to write a brief story about one experience with this individual. Emphasize that the stories should be about a colleague or coworker rather than a patient and should maintain anonymity for individuals. Allow about 10 minutes for them to complete their stories. Use the following questions to help them describe their story:

   - Describe a difficult situation with a colleague in which culture affected communication.
   - What was at issue?
   - What was (were) the cultural difference(s)?
   - What was the outcome of the interaction?

2. Before collecting the stories, ask if anyone would object to having their story read aloud. Collect and set aside the stories of people who object. Collect the remaining stories, shuffle them and then redistribute them.

3. Ask for volunteers to read a story out loud to the group. As a story is read, list the issues, cultural differences and outcomes on a flipchart. There may not be time to read every story. Discuss with the group the themes among the conflicts, cultural differences and outcomes.

4. Ask participants to think about the settings that they work in and pose the following questions to them for general discussion. Take notes on a flipchart.

   - How much cultural diversity is there among the staff at your institution?
   - In most health care settings, the higher one looks on the medical hierarchy, the less ethnic diversity one finds. Is this true in your setting? If so, how does this affect staff relations?
   - How are diversity issues among colleagues different from those encountered with patients?
   - What changes would you like to see made in your setting with regard to diversity?
   - How can you as an individual help to reduce discrimination, stereotyping or cultural miscommunication that occurs where you work?

5. Explain that cultural diversity is often a more difficult and sensitive topic to bring up when clinicians are asked to focus on their co-workers as opposed to their patients. Ask participants why this might be.

6. Transition to the next exercise.

Exercise VIIIB: Reaching Team Consensus

TIME: 60–90 MINUTES

Type of Activity
Discussion

Purpose
To give participants an opportunity to understand her/his own ethnocentrism while working with a team. This exercise is linked to Exercise VIIIC in which participants will examine how their cultural orientation affects their behavior in a group.

Learning Objectives
Participants will be able to:
1. develop awareness of their preferences in managing conflict and reaching consensus;
2. observe how they interact and problem-solve as a member of a team.

In Preparation
The objectives of this exercise are best achieved when coupled with Exercise VIIIC. In the first instance participants experience team dynamics; in the second exercise participants become aware of how individual values influence behavior.

Steps

1. Have participants get into groups of 4 or 5. If possible, make sure that participants are in a group with people they don't know well. If the groups don't have enough time to discuss every question, assign 3–4 different questions to each group.

2. Distribute Handout VIIIB.1 and give the following instructions:

   - Individually, place an "A" or "D" beside each statement on the sheet to indicate whether you personally agree (A) or disagree (D) with the statement.

   - As a group, go over each statement, checking to see if *anyone* disagrees with it. If even one person disagrees, the group should change the wording so that the statement is acceptable to all members of the group.

   - You may not "agree to disagree."

   - Choose one member of your group to record the revised, acceptable statements.

MATERIALS

Handout VIIIB.1: Reaching Consensus

Handout VIIIB.2: Liver Transplantation at Best Medical Center

3. Give the group 15 minutes to work together. They will probably not finish revising all of the statements. Assure them that this is okay.

4. While the groups are working, the trainer(s) should unobtrusively observe the dynamics of each group. These observations will be useful to the facilitation of Step 8 of this exercise, particularly if participants have difficulty identifying their group dynamics. If there are several facilitators for this session, each facilitator should observe a group and record examples of the group's dynamics using the following outline:

   - Was there a leader in the group? What behaviors identified this person?
   - Were there challengers in the group? What were their behaviors?
   - Were there members who were willing to change?
   - Did others try to change opinions?
   - What behaviors encouraged consensus?
   - What behaviors discouraged consensus?

5. Reconvene the participants and ask each group to report on a couple of their revised statements and ask for alternate revisions from other groups. Spend only a few minutes eliciting the revisions and move on to the next step, which is the focus of this exercise.

6. Explain that the purpose of this exercise is to give participants an opportunity to interact in a team. Ask them to reflect back on their own behavior in their team. Ask the following questions:

   - How difficult was it to negotiate agreement?
   - Were individual opinions valued?
   - Were there people who were willing to change? Were there people who wanted to change other's opinions?

7. Explain to participants that this exercise shows how difficult it can be to move beyond personal biases and ethnocentrism and how difficult it can be to form non-ethnocentric or nonjudgmental statements.

8. At the end of the session, ask each observer to describe their observations from Step 4. Ask them to focus on behaviors they observed. Individual identities should not be given when describing behaviors to the large group. Ask each group if the observations seem accurate to them.

9. You can reinforce some of the issues highlighted above by having the group engage in a decision-making task posed in Handout VIIIB.2. You may choose to replace the first activity with this one, which elevates the stakes of the group's decision-making.

10. Ask participants to divide into the same small groups. Give each member a copy of the handout. Remind the group that they have 30 minutes to review the list of transplant candidates and choose one person who will receive the donor liver that will be arriving shortly. Remind the group that they must come to a consensus and that they cannot agree to disagree.

11. At the end of 30 minutes, reconvene participants into a large group and ask for feedback on this activity using the same questions as in step 6. Ask them to comment on ways in which their behaviors were different from the first small group activity.

12. Transition to the next exercise.

HANDOUT VIIIB.1

REACHING CONSENSUS

Place an "A" or "D" beside each statement on the sheet to indicate whether you personally agree (A) or disagree (D) with the statement.

_____ 1. Alternative health care is unscientific, suspect and therefore should not be paid for by health insurance companies.

_____ 2. Part of the current problem with health care is that more and more social issues, such as drug use, are now considered medical problems.

_____ 3. Health care delivery would be much easier if patients got over their superstitious beliefs.

_____ 4. Health care costs are increasing because patients have unreasonable and unending demands for services and treatments.

_____ 5. While clinician-patient collaboration is important, ultimately the clinician knows best.

_____ 6. People in the U.S. have unrealistic expectations of health professionals.

_____ 7. The good patient is one who understands and complies with the treatment plan.

_____ 8. Advances in medicine are proof of America's technological and scientific superiority.

_____ 9. A government run health insurance plan is the only hope for controlling health care costs in the U.S.

_____ 10. Health professionals are not held accountable enough for the quality of the care they provide.

Adapted from Kohls, 1994.

HANDOUT VIIIB.2

LIVER TRANSPLANTATION AT BEST MEDICAL CENTER

You are a member of the transplant evaluation team at Best Medical Center (BMC). You have been asked to select **one** patient from the list below to receive the next liver transplant at BMC. The donor liver has been harvested and is on its way to your hospital within the next hour. Because of the small size of the donor liver, the entire organ must go to one individual.

Your group must come to a consensus in the next 30 minutes so that there is time to prepare the patient for transplantation. All of these individuals have been screened, are eligible for transplant and are considered a high priority because of the severity of their liver disease.

List of Candidates for Liver Transplantation

PR: A 52-year-old man with alcoholic cirrhosis. He is a smoker and has a history of hypertension that is well controlled. He also has a history of depression. He is a high school graduate who has completed 2 years of college. He is married with 2 adult children and the owner of "Lucky's Bar" for the past 20 years. He continues to work part-time running the bar. He has abstained from alcohol use for the past 3 years and quit smoking 10 years ago.

SC: A 35-year-old woman with Hepatitis C. She is thought to have contracted it from a sexual partner. She was diagnosed as being HIV infected one year ago, has normal CD4 cell counts and no history of opportunistic infections. She currently lives in shared housing that is affiliated with "Her Place" a local woman's shelter where she sought assistance after leaving her partner of 7 years because of domestic violence. She works as a peer counselor at the shelter.

GO: A 29-year-old man with chronic Hepatitis B. He contracted this through intravenous drug use. He is a smoker, has a history of eczema and a history of TB that has been treated. He is single and has been intermittently homeless for the past 8 years. Last year he completed his GED through a community organization supported by a local church. He lives in group housing and is employed at a bookstore run by the church.

YT: A 42-year-old woman with end stage liver disease due to primary sclerosing cholangitis. She also has a history of hypothyroidism. She is married with a 9-year-old child. Her husband is a professor of English at a local university. She completed an MBA and worked as a bond analyst for a large investment firm before going on disability one year ago due to fatigue. She recently began treatment for depression.

Developed by Sunita Mutha, UCSF Center for the Health Professions.

TIME: 30 MINUTES — Exercise VIIIC: Cross-Cultural Team Building

MATERIALS

Handout VIIIC.1: Cross-Cultural Team-Building Scale

Type of Activity
Discussion

Purpose
To help participants understand how culturally-influenced values can affect functioning and group cohesion.

Learning Objective
Participants will be able to identify their personal values and describe how these might affect team dynamics.

In Preparation
This exercise works best when it is coupled with Exercise VIIIB.

Steps

1. Ask participants to divide into the same small groups they were in for Exercise VIIIB.

2. Distribute Handout VIIIC.1 and ask participants to spend 5 minutes completing the worksheet individually. This handout asks participants to think about their own values, particularly as they come into play in work settings.

3. Once they have completed the handout, ask each person to partner with someone in their small group and share their self-ratings for 5–10 minutes. Remind the participants that an important ground rule for this exercise is to remain nonjudgmental. Ask the pairs to identify differences and similarities and discuss how these might affect interactions in group settings.

4. Ask participants to convene into their small groups and reflect on how they interacted during the activity in Exercise VIIIB. Ask them to discuss their profiles in their small groups, using the following discussion questions:

   - What similarities and differences in values are most notable among the group members?
   - Are you surprised by any of the responses of the group members?
   - Do the similarities and differences among group members help to explain some of the dynamics in the previous group exercise (Exercise VIIIB)? How so?

5. Reconvene the participants into the large group. Ask them to share what they found most surprising in their small group discussions.

6. Ask the group to consider how individuals develop these values.

   - What is the influence of family culture?
   - What is the influence of professional culture?
   - What differences are due to personal preferences?

7. Ask participants to consider how differences in values might be used to enhance team functioning and cohesiveness. Be sure to indicate that values can change with time and that it is important to be aware of and pay attention to differences and similarities that enhance group effectiveness and satisfaction.

8. Transition to the next exercise.

HANDOUT VIIIC.1

CROSS-CULTURAL TEAM-BUILDING SCALE

Directions: All individuals have values that affect cohesion of the groups they work in. Mark an "X" along the continuum that best describes where you fit for each item and connect the "X" marks for all items.

Value change	. . . . .	**Value tradition**
Direct communication style	. . . . .	**Indirect communication style**
Analytical, linear problem solving	. . . . .	**Intuitive problem solving**
Emphasis on individual performance	. . . . .	**Emphasis on group performance**
Communication primarily verbal	. . . . .	**Communication primarily nonverbal**
Emphasis on task and product	. . . . .	**Emphasis on relationship and process**
Openly express disagreement	. . . . .	**Try to maintain group harmony**
Informal tone	. . . . .	**Formal tone**
Competition	. . . . .	**Collaboration**
Rigid adherence to time	. . . . .	**Flexible adherence to time**

Adapted from Gardenswartz, 1994.

Exercise VIIID: Cross-Cultural Conflict Resolution

TIME: 60 MINUTES

Type of Activity
Lecture / Discussion

Purpose
To help participants recognize how cultural differences can be at the root of conflict and how conflict resolution skills can be helpful in managing these differences. This exercise will introduce participants to steps that can be taken to resolve conflicts among colleagues and staff in a culturally sensitive way.

Learning Objectives
Participants will be able to:
1 identify causes of conflict;
2. list ways in which culture can affect interpersonal conflict and;
3. identify specific steps that can be taken to respond to conflict in a culturally sensitive way.

MATERIALS

- Overhead VIIID.1: What Produces Conflict?
- Overhead VIIID.2: Understanding How Cultural Norms Affect Conflict
- Overhead VIIID.3: Strategies for Resolving Conflict
- Flipchart / markers
- Personal vignettes from Exercise VIIIA

Steps

1. Ask participants how they would define conflict. As a simple definition offer the following:

   > Conflict is a disagreement between two or more parties who perceive the same event differently due to difference in attitudes, beliefs, values or needs.

   Ask the group to identify what produces conflict. You may want to consider writing the comments on a flipchart.

2. Show Overhead VIIID.1. Remind the group that conflict can also lead to positive outcomes such as growth and innovation as well as new ways of thinking. Ask the group to identify other positive outcomes that can result from situations of conflict. Keeping this in mind, the remainder of the exercise will focus on the more difficult aspects of conflict and skills for managing these situations in culturally sensitive ways.

3. Read the following example of a conflict exacerbated by cultural differences:

   In a disagreement between two employees, one African-American and the other a Filipina, a few heated words were exchanged. Wanting to avoid an escalation of the conflict, the Filipina employee walked away. The African-American employee, on the other hand, valuing direct confrontation of conflict and wanting to settle the problem, followed her co-worker, trying to talk to her. This only caused more anxiety and panic for the Filipina woman, who had been taught to value harmony and smooth interpersonal relationships. So she continued to refuse to discuss it. When the African-American woman persisted, the Filipina turned and threatened her co-worker, telling her if she came any closer, she would hit her. What resulted was a grievance where both employees reported being physically threatened by the other.

4. Ask the group to discuss what perceptions of each employee can be explained by cultural differences. Explain that while there are significant individual differences in communication style, there are also culture- and gender-based ways to handle conflict. Ask participants how they think this conflict could have been avoided or defused and write their answers on the flipchart.

5. Explain that although the dominant American culture places a high value on direct communication, some people tend to avoid conflict and confrontation and hope that it will go away on its own. This can be wishful thinking, as conflicts that are not dealt with have a tendency to worsen and can result in a more serious conflict in the future. Unresolved conflict can be a significant source of stress and can negatively affect both individuals and the organizations they work for. Dealing with conflict is important, and cultural differences can add to this challenge.

6. As an optional step you might want to refer back to the personal vignettes that the group wrote in Exercise VIIIA. Refer to Overhead VIIID.1 as you identify the causes of conflict in the scenarios.

7. Present Overhead VIIID.2 using the following information:

   - **Conflict is seen as disruptive to harmony**. Many cultures place a high value on harmony and smooth interpersonal relations. Therefore, individuals may avoid conflict at almost any cost.

   - **There are differences in verbal communication styles**. One aspect of communication style is use of language. Across cultures, some words and phrases are used in different ways. For example, even in countries that share the English language, the meaning of "yes" varies from "maybe, I'll consider it" to "definitely so," with many shades in between.

   - **There are differences in nonverbal communication**. Non-verbal communication includes not only facial expressions and gestures; it also involves seating arrangements, personal distance, and sense of time. In addition, different norms regarding the appropriate degree of assertiveness in communicating can add to misunderstandings. For instance, some cultures consider raised voices to be a sign that a fight has begun, while others may feel that an increase in volume is a sign of an exciting conversation. Thus, the former may react with greater alarm to a loud discussion than would members of the latter group.

   - **Conflict presents a risk of loss of face**. Because conflict sometimes leads to accusations, blaming and arguments, there is a great risk of embarrassment. People from some cultures will be reluctant to participate in any interactions that could lead to someone losing face. For them, reducing the potential of loss of face is very important.

   - **There are differences in approaches to completing tasks**. There can be cultural differences in the ways that people complete tasks. Some cultures have different notions about the rewards associated with task completion, different concepts of time, and varied ideas about how relationship-building and task-oriented work should go together. As a generalization, Asian and Hispanic cultures may attach more value to developing relationships at the beginning of a shared project and more emphasis on task completion toward the end. Those who share European-American culture may tend to focus immediately on the task at hand, and let relationships develop as they work on the task.

- **Decision-making styles differ.** In the U.S., decisions are frequently delegated, that is, an official assigns responsibility for a particular matter to a subordinate. In other cultures, there is a strong value placed on holding decision-making responsibilities to oneself. When decisions are made by groups of people, majority rule is a common approach in the U.S. In countries such as Japan, consensus is the preferred mode.

- **Attitudes toward disclosure may differ.** In some cultures, it is not appropriate to be frank about emotions, about the reasons behind a conflict or a misunderstanding, or about personal information. Questions that may seem natural to some — What was the conflict about? What was your role in the conflict? What was the sequence of events? — may seem intrusive to others.

- **There are different approaches toward knowing.** Notable differences occur among groups when it comes to epistemologies, that is, the ways in which people come to know things. Some cultures and individuals consider information acquired through cognitive means, such as counting and measuring, more valid than knowledge gained by experiences. Some individuals may want to do research to understand a shared problem better and identify possible solutions. Others may prefer to visit places and people who have experienced similar challenges, and "touch, taste and listen" to what has worked elsewhere.

- **There is a risk that a conflict may be interpreted as discrimination and prejudice.** Among groups that have had a history of discrimination, there may be a heightened sensitivity to prejudice and racism and there may be a tendency to perceive unwanted feedback or confrontation as discriminatory.

8. Present Overhead VIIID.3. Explain that you will be discussing some strategies for handling conflict. Encourage discussion as you review the strategies. When presenting this material, use concrete examples whenever possible to help participants fully grasp the content. Also, explain to participants that a mediator, or an acknowledged leader of a group, may be helpful in resolving a conflict, provided that both individuals agree on who the mediator will be. The following steps can be used either with or without a mediator, but will probably be more effective with a mediator.

- **Set ground rules/use "I" statements.** When trying to resolve a conflict, it is important that each side be able to listen to the other without letting defensiveness take over. Name-calling, accusations and blaming are used for self-protection but only serve to escalate a conflict. Before starting a process of conflict resolution, the mediator can remind each person in conflict to observe the ground rule of speaking only about his/her experience (using "I" statements), rather than making accusations or speaking for the other person. It is likely that people will become defensive during mediation, therefore the mediator may need to remind each individual of the ground rule several times during the mediation.

- **Find out what are the differences in perception.** What is each person's story? To define the problem from both points of view, ask each person what his/her point of view is. How does s/he view the conflict? Remember, it is important that each person talk about what happened and how s/he experienced it, not about the other person and what is wrong with her/him. It is important that judgment of the other person not be a part of the storytelling. Note that for some individuals, cultural attitudes toward disclosure may make this difficult (see above).

- **Uncover cultural interpretations/assumptions.** What assumptions is each person making about the other, based on his/her own cultural perspective?

- **Create a bridge of understanding.** At this stage, it is important that each person begins to accept responsibility for her/his part of the conflict, including the assumptions s/he made about the other person.

- **Meet halfway to create a solution.** The most important part of this process is the recognition and acceptance of others' cultural values. This will make resolution more likely. Resolution may involve coming to a deeper understanding of the reasons for the other person's actions, or it may involve working out a mutually acceptable solution. Both people may need to give something up in order to achieve resolution and the mediator can assist in brainstorming possible solutions.

- **Learn from generalizations about other cultures**. But don't use those generalizations to stereotype, "write off," or oversimplify your ideas about another person. The best use of a generalization is to add it to your storehouse of knowledge so that you better understand and appreciate other interesting, multi-faceted human beings. Remember that cultural norms may not apply to the behavior of any particular individual. We are all shaped by many, many factors—our ethnic background, our family, our education, our personalities—and are more complicated than any cultural norm might suggest.

- **Don't assume that there is one right way (yours) to communicate**. Keep questioning your assumptions about the "right way" to communicate. For example, think about your body language; postures that indicate receptivity in one culture might indicate aggressiveness in another.

- **Listen actively and empathically**. Stop, suspend judgment, and try to look at the situation as an outsider. Try to put yourself in the other person's shoes. Especially when another person's perceptions or ideas are very different from your own, you might need to operate at the edge of your own comfort zone.

- **Respect others' choices about whether to engage in communication with you**. Honor their opinions about what is going on and their willingness to discuss the conflict.

- **Be prepared for a discussion of the past**. Use this as an opportunity to develop an understanding from "the other" point of view, rather than getting defensive or impatient. Acknowledge historical events that have taken place. Be open to learning more about them. Honest acknowledgment of the mistreatment and oppression that have taken place on the basis of cultural difference is vital for effective communication. Awareness of current power imbalances, and openness to hearing each other's perceptions of those imbalances, is also necessary for understanding each other and working together.

- **Check your interpretations as you go**. If you are uncertain about what is meant in a conversation it can be helpful to ask for clarification. By reviewing your understanding, you are also indicating that you are actively listening.

- **Practice, practice, practice**. This may be one of the most important guidelines, because it is in the doing that we actually get better at cross-cultural communication and conflict resolution.

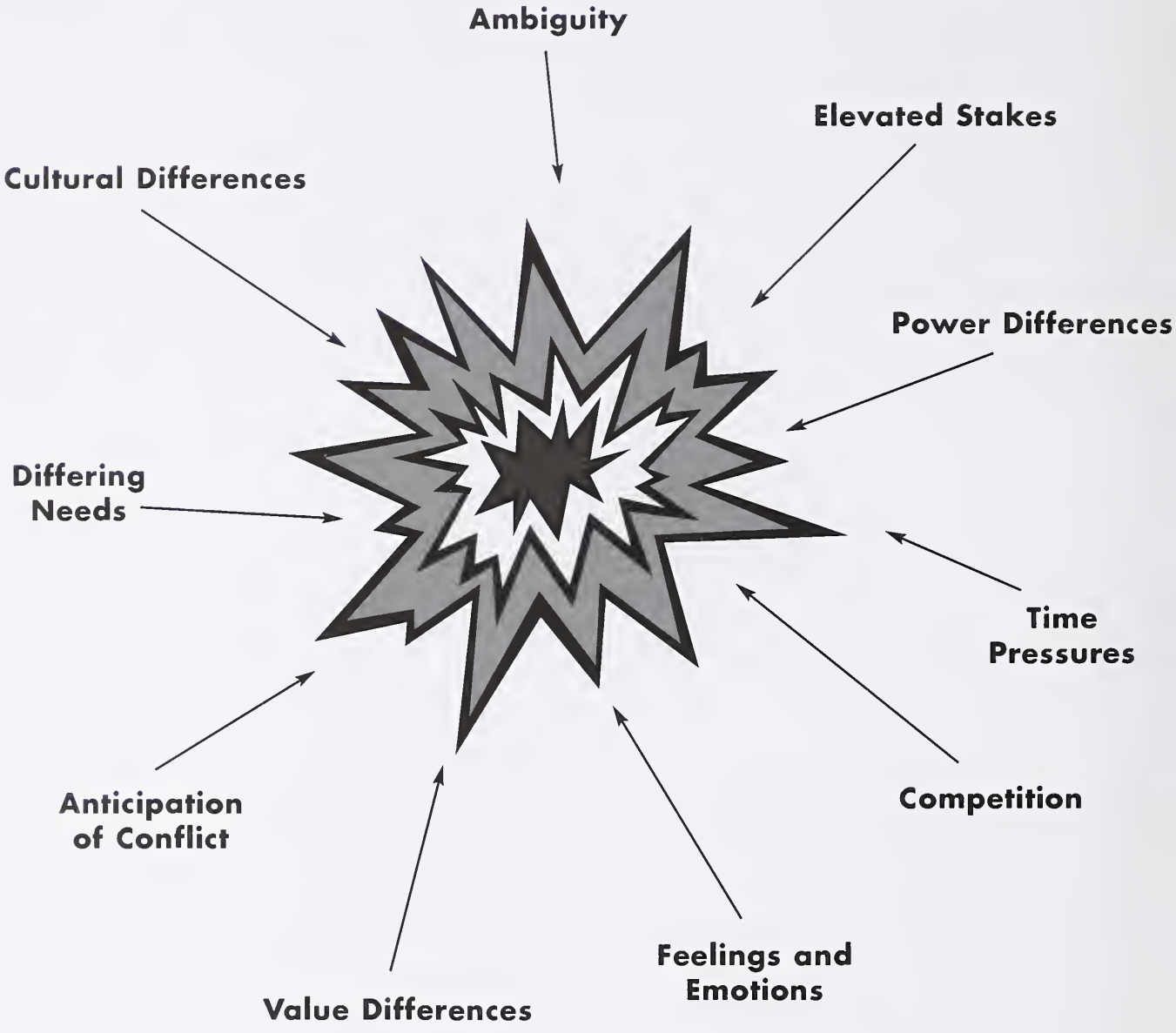
9. Ask participants to share their own experiences with these strategies or others that they've used. How easy or difficult are they to use? Why? How effective were different strategies?

10. You may want to include a simulation in this activity. Participants will learn the most about conflict resolution by actually doing it, but it is a high-risk activity and may make participants uncomfortable if they don't feel safe. You can consider using the vignettes generated in Exercise VIIIA and asking individuals to role-play a different outcome to the written scenario using the strategies you've reviewed.

11. Transition to the next exercise.

OVERHEAD VIIID.1

WHAT PRODUCES CONFLICT?



Developed by Sunita Mutha, UCSF Center for the Health Professions.

OVERHEAD VIIID.2

UNDERSTANDING HOW CULTURAL NORMS AFFECT CONFLICT

- Conflict is seen as disruptive to harmony.
- There are differences in verbal communication styles.
- There are differences in nonverbal communication.
- Conflict presents a risk of loss of face.
- There are differences in approaches to completing tasks.
- Decision-making styles differ.
- Attitudes toward disclosure may differ.
- There are different approaches toward knowing.
- There is a risk that a conflict may be interpreted as discrimination and prejudice.

Developed by Sunita Mutha, UCSF Center for the Health Professions.

OVERHEAD VIIID.3

STRATEGIES FOR RESOLVING CONFLICT

- Set ground rules/use "I" statements.
- Find out what are the differences in perception.
- Uncover cultural interpretations/assumptions.
- Create a bridge of understanding.
- Meet halfway to create solution.
- Learn from generalizations about other cultures.
- Don't assume that there is one right way (yours) to communicate.
- Listen actively and empathically.
- Respect others' choices about whether to engage in communication with you.
- Be prepared for a discussion of the past.
- Check your interpretations as you go.
- Practice, practice, practice.

Developed by Sunita Mutha, UCSF Center for the Health Professions.

Exercise VIIIE: Resolving Conflict and Avoiding Collusion

TIME: 60 MINUTES

Type of Activity
Discussion/Simulation

Purpose
To give participants a chance to discuss and practice strategies for dealing with specific incidents involving stereotypes, discrimination or cross-cultural conflict.

Learning Objectives
Participants will be able to:
1. implement strategies for handling situations involving stereotypes, discrimination and cross-cultural conflict;
2. identify strategies to avoid colluding with stereotypic or discriminatory remarks.

In Preparation
The five critical incidents are intended to be used as simulations and to generate discussion. Participants should act out the given incident using possible solutions suggested by the group to the problem presented. The critical incidents can easily be altered to include different types of clinicians. You may also choose to have participants work with the vignettes that they wrote in Exercise VIIIA.

MATERIALS

Handout VIIIE.1: Critical Incidents (1 through 5)

Overhead VIIIE.2: How to Avoid Colluding

Flipchart/markers

Steps

1. Divide participants into small groups of 4–5 and give each participant a copy of Handout VIIIE.1. Ask the groups to collectively discuss and answer the questions under each of the incidents. Tell the small groups that they will have about 30 minutes for discussion and that they do not have to finish all of the incidents. Encourage participants to add to the incidents by discussing their personal experiences with the group. To make sure that every incident is discussed, have some groups start on #3 or #4 and work their way from there.

2. After approximately 30 minutes, reconvene as a large group and ask participants to share comments from their small group discussions about any of the incidents. Encourage participants to share personal incidents if they are comfortable and describe how they dealt with them.

3. Ask for volunteers to act out some of the critical incidents. Summarize the incident and ask the volunteers to focus on arriving at either resolution or compromise. Encourage participants to use the conflict resolution skills they learned in Exercise VIIID. Depending on the safety level in the group, participants should also be encouraged to use their own incidents that they wrote about in Exercise VIIIA as simulations.

4. Before beginning the simulations you may want to encourage volunteers to identify one or two specific strategies that they want to practice using in a simulation. Encourage them to use strategies that they are not currently comfortable with, but would like to try. For each simulation, remind observers that they will be asked to provide feedback to the participants after the simulation. When the volunteers have concluded, thank them and ask the observers to provide feedback on what they observed; what went well and what they might change. Review Overhead VIIID.3 used in the previous exercise. Ask the group if they would add anything to this list.

5. Discuss with the group that so far the focus has been on identifiable conflict with one or more individuals. Ask participants to think of experiences in which they did not experience direct conflict, but heard comments or experienced actions in which group members or others were treated in a discriminatory or stereotypical manner. Examples include the use of racial slurs or ethnic humor. Ask them to discuss how they have dealt with these situations in the past. You may want to list the strategies on a flip chart.

6. Explain to the group that silence in the face of slurs, stereotyping and other remarks that make them uncomfortable can be described as collusion. Their silence in such settings can be seen as agreement or cooperation with these statements or actions. These situations can be painful and difficult. Remind the group that each of us has some responsibility for challenging biases and stereotypes.

7. Present Overhead VIIIE.2 and suggest that these are some strategies that they can use when they are trying to avoid colluding with discriminatory, or stereotypic remarks.

8. Ask the participants to return to their small groups. Highlight examples of collusion in the "Critical Incidents" and ask the participants to apply some of the strategies to these situations. Allow 10 to 15 minutes for this activity and then instruct the groups to review the effectiveness of the strategies and to add others that might also be useful.

9. Bring the group back together and ask participants to describe other strategies that they feel could be used to address unwelcome remarks. Remind the group that while it is uncomfortable to confront slurs and stereotyping, it can be more uncomfortable to be in the position of appearing to collude.

10. Review the lessons learned and transition to the next exercise.

HANDOUT VIIIE.1.1

CRITICAL INCIDENTS

Critical Incident #1

Marcia is an African-American medical student on her third-year medicine clerkship. Late one night she is sent to start an IV on an elderly patient with terminal ovarian cancer. When Marcia tells the patient that she is going to help to re-start her IV, the patient yells, "I don't want no black doctor!"

Discussion Questions

- How would you feel if you were Marcia?
- If you were Marcia, what would you say or do at this point?
- How should students and residents learn to anticipate or deal with racial or cultural prejudice from their patients?
- What obligation does a clinician have to treat a patient who insults her or him? What kinds of limits should a clinician be able to set in such a situation?

Critical Incident #2

Dr. Go is winding down rounds with a patient in the Neurology ICU. He is a consultant to the case. He is advising his team about recommendations for the case as a woman attends to some of the patient needs. Dr. Go addresses the woman assisting the patient, "Excuse me, nurse, could you let me know..." Dr. Go doesn't know that the woman, Dr. Hansen, is the Neurology Chief Resident.

Discussion Questions

- How would you feel if you were Dr. Hansen?
- What would you say if you were Dr. Hansen?
- How common is this type of assumption?
- What could Dr. Go have done differently?
- If the genders of Dr. Go and Dr. Hansen were switched, how likely is it that the same incident would happen?

Welch, 1999.

HANDOUT VIIIE.1.2

CRITICAL INCIDENTS (continued)

Critical Incident #3

At a celebration lunch, two medical students, an intern and a resident are winding down their first month on the ward. The team is chatting freely about the rigors of patient care. The group is talking about one of their patients who is gay. The intern comments that he just doesn't understand why people are gay. One of the medical students, who is gay, becomes quiet and withdrawn. The only person in the group who knows that the student is gay is the other medical student.

Discussion Questions

- How would you feel if you were the gay medical student?
- If you were the student who knows the other student's sexual orientation, what would you do?
- How does the power and the medical hierarchy affect this situation?
- What are some strategies both students could use in this situation?

Critical Incident #4

Dr. Meyers, the chief resident, has just seen Mrs. Aguilar, a Latino female patient who believes she has susto. Dr. Meyers calls Angela Garcia, a Latina nurse practictioner, into her office and asks her to take over the care of the patient, saying, "Mrs. Aguilar has some traditional beliefs which are getting in the way of my caring for her. Being Latina, you can probably understand all of that superstition."

Discussion Questions

- To what extent do you agree or disagree with Dr. Meyers' decision?
- What value statements and assumptions is Dr. Meyers making, both about the patient's culture and about Ms. Garcia's culture?
- How would you feel if you were Ms. Garcia?
- What would you do if you were Ms. Garcia?
- If Ms. Garcia is familiar with Latino folk illnesses, does she have any obligations to educate Dr. Meyers about Mrs. Aguilar's "traditional beliefs?"

Welch, 1999.

HANDOUT VIIIE.1.3

CRITICAL INCIDENTS (continued)

Critical Incident #5

An older Caucasian woman in the lobby of a hospital stops a young African American orthopedic resident who is wearing a laboratory coat. She asks him to help carry her suitcases to a taxi. The resident is late for an appointment with a patient.

Discussion Questions

- If you were the physician, what would you do and say?
- How would you feel after this interaction if you were the physician?
- How common are racial stereotypes that a black male, despite his "official" clothes, couldn't be a physician?
- Does a hospital or medical school have any obligation to directly address such issues with residents? With patients?

Welch, 1999.

OVERHEAD VIIIE.2

HOW TO AVOID COLLUDING

When addressing slurs, stereotyping or discriminatory remarks:

- Be prepared for defensiveness.
- Consider the timing and place for such discussions (public vs. private, immediate vs. delayed, etc.).
- Be aware of your triggers.
- Choose your battles.

Strategies to address slurs, stereotyping or discriminatory remarks:

- Use "I" statements.
  Example: *When you say* _____ *I feel* _____.
- Specify the stereotyping or discriminatory comments.
  Example: *I think it's stereotyping when you say* _____."
- Suggest alternative ways of perceiving the situation.
  Example: *You might not think that statement is offensive, but from my perspective as a* _____, *it is.*
- Focus on the action, not the individual.
  Example: *That statement you made offended me because* _____.
  (As opposed to: You offended me.)

Developed by Sunita Mutha, UCSF Center for the Health Professions.

SECTION IX

The Culturally Competent Health Care Setting

Introduction

Up to this point we have focused primarily on interpersonal interactions. We now consider the roles and responsibilities of health care organizations in assuring culturally appropriate care for their communities. We begin with an overview of the components that are important to the creation of culturally competent institutions. Next, we consider specific areas to address in organizational action plans, including: staff recruitment, the structure and delivery of clinical services, community partnerships, administration responsibilities and leadership commitment. The section includes an organizational assessment template than can be used to determine where a given organization is on the continuum of culturally competent health care delivery.

The Culturally Competent Institution

Just as the cultural competency of an individual can be viewed on a continuum (see Section I), so can the cultural competency of the health care organization. The CLAS Standards (see Section III) represent the ideal in the delivery of culturally competent health services and establish goals for organizations to strive toward over time. Like individual cultural competency, the process of assessing organizational cultural competency requires ongoing review, self-assessment, and planning. Depending on the entity, some standards may be achieved with relative ease and others may require fundamental organizational change. This section challenges us to consider issues such as racism, prejudice and bias and to address them in the structure and function of our organizations with the goal of improving the quality of health care for our communities.

Learning Objectives

At the conclusion of Section IX the learner will be able to:

1. identify characteristics of culturally competent health care organizations;
2. describe approaches to improving an organization's cultural competency in the arenas of clinical care, community partnerships, administration and leadership;
3. apply one approach to assessing the cultural competency of an institution and identify the implications of this assessment for organizational planning.

Exercise IXA: Components of Culturally Competent Organizations — TIME: 60 MINUTES

Type of Activity
Discussion

MATERIALS

Flipchart / markers

Purpose
To help participants identify the components and characteristics of culturally competent health care organizations.

Learning Objective
Participants will be able to identify the components and characteristics of culturally competent health care organizations.

In Preparation
We have found this section to be an essential component of trainings because it addresses the context in which individuals work and in which cultural competency skills will be put into practice. The content can be challenging to address because of its breadth and scope. The most effective approaches are likely to be those that allow adequate time for discussion and that use co-facilitators who can represent organizational perspectives such as those of the employment office, human resources, senior management, and leadership trainers.

There are a variety of approaches that institutions can adopt to provide culturally appropriate care. The U.S. Office of Minority Health's CLAS Standards serve as a guide for organizations in the design of "culturally and linguistically appropriate services" to their communities. The fourteen standards describe improvements that can be made in such areas as patient care, staff recruitment and training and administrative structure.

Another approach focuses on conducting comprehensive assessments of an organization's ability to deliver culturally competent care through the use of protocols, structured interviews, and triangulation of other data. The Cultural Competence Self-Assessment Protocol (Andrulis, 1999) is one example. This protocol links cultural competence to four "cornerstones" that include relationships between and among: the organization and the community, patients and clinicians, staff members, and administration and staff. Organizational self-assessments can highlight strengths and identify challenges and can be used to embark on a planning process for identifying priorities and developing an implementation plan.

Familiarize yourself with the content that follows and identify examples for each category from your experiences, focusing on barriers and facilitators to achieving the types of actions identified in these categories.

Clinical Care

In the clinical setting the health care organization has the responsibility both to establish patient care guidelines and to assist staff in the implementation of the guidelines. Some actions that organizations can take include:

- Commit resources to establish and maintain staff training in cultural competency
- Hire and support a diverse clinical staff that reflects the patient population
- Develop guidelines that help staff provide culturally appropriate interventions that include, for example, a willingness to work with traditional healers and acceptance of concomitant CAM practices
- Develop a policy that encourages appropriate use of trained interpreters
- Encourage interdisciplinary teams for managing complex clinical care

Health care organizations can improve patient outcomes by incorporating population-based information into patient care guidelines. This information might include:

- Recognize diverse health beliefs, how they impact care and the acceptance of care. Such recognition should include cultural sensitivity and awareness of the difference between the culture of medicine and the cultures of groups, such as ethnic groups.
- Use epidemiologic data to guide understanding of and decision-making about patient care issues. These data should focus on the incidence of disease in targeted cultural groups.
- Develop treatment plans based on the unique characteristics of the targeted population rather than on the needs of the organization or the general population. An understanding of population-based response to treatment can ultimately affect diagnosis and treatment protocols as well as pharmacy formularies.

Contemporary practice relies increasingly on a partnership between the clinician and an informed patient. Health care organizations can promote such a partnership through an active patient education program that includes:

- A health education staff with language capacity reflecting the diversity of the community being served
- Health education materials written in the language(s) of the community
- Facility signage in languages reflective of the patient community
- A commitment to community outreach that brings appropriate health education materials to local venues
- Materials informing patients of their rights under law to receive respectful and non-discriminating treatment

Community Partnerships

Outreach to community-based organizations and to community leaders is an important way for organizations to learn about their patient populations and to demonstrate commitment to quality care for diverse groups. Some actions that can be taken include:

- Establish a community advisory council and a commitment to a serious, two-way exchange of information about the needs of the community and the practices of the organization
- Participate in and sponsor, when possible, community activities such as health fairs, school health events and community health initiatives
- Establish a "good neighbor" policy that encourages activities such as providing meeting space for community events, serving on community committees, promoting personal relationships between organization staff and community leaders

Administration Responsibility

The actions at the administration level clearly demonstrate institutional commitment to cultural competency for the entire organization. Some key actions that administration leaders can take to promote organizational cultural competency include:

- Develop a human resources strategic plan that outlines how the organization will recruit and retain a diverse staff that reflects the community
- Include cultural competency standards into all aspects of the institutional strategic plan for such areas as human resources, marketing, patient care, patient education, staff training, community liaison, etc.
- Design user-friendly materials about the organization in appropriate languages used by the community
- Assure the physical plant is welcoming and include signage and materials in appropriate languages
- Establish a timeline and work plan for the adoption of CLAS Standards and assign a senior administrator the responsibility for implementation

Leadership Commitment

In addition to specific administrative actions, there are important activities that can be undertaken by the leadership to assure that the organization's vision and values reflect the importance of cultural competency. These include:

- Provide cultural competency training at Board or Trustee level to inform and enlighten those who are making major institutional decisions
- Provide cultural competency training for administrative staff
- Establish CLAS Standards as an organizational priority with a mandate to administration to develop an implementation plan
- Include community leaders, on the board of directors, on board committees and on community advisory boards
- Create an organizational mission statement that includes a commitment to a diverse staff and culturally sensitive care for patients

Steps

1. Ask participants to consider the following questions about their current health care settings. Write their responses to these questions on a flipchart.
   - What types of activities does your organization do to promote cultural competency? Give specific examples.
   - In what ways is the surrounding community involved with your organization?
   - Are topics of diversity and culture included in trainings, courses, etc?
   - How much interaction is there between employees from different cultural backgrounds?
   - What does the organization do to attract a diverse workforce?

2. Ask the group to brainstorm about the criteria that they would use to determine whether or not an organization is culturally competent. You may want to suggest that they use the answers to the first questions as a starting point. If they get stuck, use examples from the materials summarized in the preparation section above.

3. Present the group with a summary of the categories described above (clinical care, community partnerships, administrative responsibility, and leadership commitment) or components of the CLAS Standards. Ask them to discuss how helpful they find this information in identifying roles and responsibilities of an organization. Ask them to identify areas that are missing from this list. Ask the group to come to a consensus on identifying the five most important characteristics of a culturally competent organization.

4. Using the list of the five most important characteristics, ask the group to identify ways in which these characteristics could be measured or observed. Encourage them to be specific when brainstorming. Ask them to describe what this measurement might reveal.

5. Summarize and transition to the next exercise.

TIME: 60 MINUTES

Exercise IXB: Assessing an Organization's Cultural Competency

MATERIALS

Handout IXB.1.1–IXB.1.2: Assessing the Cultural Competency of Your Organization

Type of Activity
Discussion

Purpose
To introduce an approach to assessing the cultural competency of an institution and to identify the implications of this assessment for organizational planning.

Learning Objectives
Participants will be able to:
1. use a template for assessing the culturally competency of an institution;
2. describe the implications of this assessment for organizational planning.

In Preparation
If you are not familiar with the organizational settings of the participants, you may want to consider using a survey or other methods to obtain this information prior to this session. Review Handout IXB.1.1–IXB.1.2 and determine any modifications that need to be done, based on the practice settings of the participants. During the exercise you will need to remind the group that they may not feel they have all the necessary information to complete the template, but they should attempt to fill it out to the best of their abilities and select the "can't rate" option only when needed.

Steps

1. If the participants have not gone through Exercise IXA, you may want to summarize the content of that session as a starting point for this discussion so that they are familiar with the categories of clinical care, community partnerships, administrative responsibility and leadership commitment. You may also want to remind them of the CLAS Standards as they relate to organizational issues.

2. Ask participants to take 10 minutes to individually complete Handout IXB.1.1–IXB.1.2.

3. When they have finished completing the handout, reconvene the group. Depending on the amount of time available, review each theme or select specific themes by asking participants how they rated their current settings.

4. Remind the participants that the first response column often reflects the current efforts in health care settings and that the third column reflects efforts that are likely to be characteristic of an ideal environment. Reassure them that it's likely that very few organizations would be able to rate themselves as meeting all of the criteria in the third column.

5. Ask which parts of the form they had difficulty completing and why. Ask for reasons why they used the "can't rate" response. What would have to happen at the participants' institution to allow them to rate these items? Possible responses might include: better organizational communication, more commitment from leadership, clarification of values, goals or mission statement, etc.

6. Ask the group to brainstorm about the steps needed to move their organizations from their current status toward the descriptions in the third column. What are the barriers preventing change? What might facilitate change?

7. Ask the group to identify themes that are important and have not been included in this survey.

8. Summarize and transition to the next exercise.

HANDOUT IXB.1.1

ASSESSING THE CULTURAL COMPETENCY OF YOUR ORGANIZATION

Instructions: Each of the following themes is followed by a series of descriptions. For each theme, please check the description that best describes your health care setting.

THEMES	DESCRIPTIONS
Staff training	☐ I do not know of cultural competency trainings for staff. ☐ I know that cultural competency trainings are being developed. ☐ I know that cultural competency trainings exist and are provided on a regular basis. ☐ Can't rate.
Staff recruitment	☐ Little effort is made to do outreach to recruit a diverse staff. ☐ We make an attempt to recruit a diverse staff, but often this doesn't work. ☐ There is an organizational commitment and a plan for recruiting a diverse staff. ☐ Can't rate.
Measurement and monitoring	☐ We collect data about health outcomes for our community. ☐ We collect health outcomes data and use it to inform the services we provide for our community. ☐ We routinely provide care that is based on health outcomes data and measure the effect of this care on the health of our community. ☐ Can't rate.
Patient education	☐ We have reading materials in some of the languages of our community. ☐ We provide comprehensive materials in all languages represented in our community. ☐ We have comprehensive materials and offer patient education courses in the languages of our community. ☐ Can't rate.
Medical interpreters	☐ We have access to staff that can interpret for us. ☐ We have access to trained interpreters. ☐ We have consistent access to trained interpreters and are trained in how to work with them. ☐ Can't rate.

Developed by Sunita Mutha and Carol Allen, UCSF Center for the Health Professions.

HANDOUT IXB.1.2

THEMES	DESCRIPTIONS
Connection to community	☐ We focus on patients who come to our facility. We have not done any outreach programs. ☐ We have had some successful outreach programs and have at times solicited community involvement. ☐ We solicit community involvement for all outreach programs and actively provide resources for such programs. ☐ Can't rate.
Institutional investment	☐ Resources ($$, time) are not available for providing culturally competent care. ☐ Resources ($$, time) are available for providing culturally competent care and we occasionally use them. ☐ Resources ($$, time) are available and routinely used for providing culturally competent care. This is a priority for our institution. ☐ Can't rate.
Administrative support	☐ Cultural competency is on the radar screen but often gets overlooked because of more pressing issues. ☐ All departments have been asked to develop a cultural competency action plan. ☐ The strategic plan includes concrete steps to improve cultural competence at all levels. A senior administrator has been assigned to implement the plan. ☐ Can't rate.
Institutional leadership	☐ Our leadership has identified cultural competency as a concern. ☐ Our leadership has made cultural competency a priority and is working on an implementation plan and timeline. ☐ Our leadership reflects the community we provide care for and there is commitment from Board/Trustee level to assure cultural competency throughout the organization. ☐ Can't rate.

Developed by Sunita Mutha and Carol Allen, UCSF Center for the Health Professions.

SECTION X

Evaluating the Impact of Your Training

Introduction

Evaluation is a critical task that can provide valuable information about the effectiveness of a program, so as to optimize the outcomes, efficiency and quality of trainings. Evaluations can also be used to analyze a program's structure, activities, and the achievement of goals and objectives. Ideally, some evaluators would also like to be able to demonstrate the link between the content of an educational program and the impact on patient outcomes. This is an especially challenging task. Currently, there are no widely available validated tools for evaluating cultural competency and efforts to link cultural competency training and patient outcomes are in their infancy. While such tools are being created, tested and validated, our focus in this section will be on the purpose, needs and the essential components of evaluation design.

Why Evaluate?

- The evaluation forces the trainer to think carefully about what s/he wants to achieve in the training program and to write learning objectives that are clear and attainable. A well-designed evaluation is dependent on well-conceived learning objectives and standards of effectiveness. If objectives are clearly thought out and measurable, then the evaluation can be easily formulated. So, while the evaluation is often the last component of a training program, it should be integrated into the program planning when the trainer is considering the knowledge, skills and attitudes s/he hopes to impact.

- The evaluation provides critical information to the trainer about his/her teaching and facilitation ability, the content of the training and the organization and pacing of the program. Whether the trainer is new or highly experienced in cultural competency training, the feedback from the learner in the form of an evaluation, is invaluable to subsequent program planning and presentation.

- The evaluation gives the trainer immediate feedback about the success of the program in helping the learner acquire new knowledge, skills and attitudes. While the trainer may not be able to draw conclusions about how behavior will change in the clinical setting, at minimum s/he can describe the extent to which the learners acquired new information and reported confidence in applying new behaviors in their work settings.

- If the trainer is planning on conducting several workshops with the same audience, s/he can use each evaluation to plan and refine future trainings. This ongoing feedback can be used to assess effectiveness of teaching methods, the acquisition of new knowledge, as well as changes in skills and attitudes. The trainer can also use this information to identify areas for subsequent trainings.

- From an institutional perspective, the evaluation can provide important information about the level of cultural awareness and competency of its clinical staff. Such an assessment is most useful when it is combined with a pre-training survey of baseline knowledge, skills and attitudes so that change can be measured with some degree of confidence.

- Finally, evaluations are necessary for fulfilling requirements for continuing education accreditation or course requirements.

Evaluation Questions

Without resources to mount an extensive evaluation, what questions can the trainer realistically ask and answer that will be useful to future programs and to the sponsoring organization? We suggest that the most important categories to address include the impact of training, effectiveness of the trainer(s), and relevance of the content to the participants.

1. Immediate impact of the training on participant learning:
   - What new knowledge did the trainee learn?
   - What new skills might the trainee apply in the clinical setting?
   - How confident is the trainee in his/her ability to apply these new skills?
   - What attitudes changed as a result of the training?
   - How useful was the content of the training to the needs of the participants?

2. Effectiveness of the trainer(s):
   - How effective was the trainer in conveying the information?
   - Was sufficient time given for the exercises and questions and answers? Was the pace of the training conducive to learning?
   - Did the trainer's facilitation skills provide a safe environment for exchange of ideas, feelings and attitudes?
   - Were the objectives of the training achieved? Were the materials presented in a manner that was clear and helpful?
   - Does the learner have recommendations for improving the training?

3. Application of the training to the learner's clinical setting:
   - What behaviors has the trainee acquired or changed as a result of the training?
   - What behaviors will the trainee continue and discontinue as a result of the training?
   - What important "take-home" lessons has the trainee identified?
   - What changes in practice, teaching, etc. does the trainee plan to make as a result of the program?

Most current evaluations are limited to participants' self-assessments of attitudes, skills and behaviors. There are some exciting reports of objective measurements such as the use of Objective Structured Clinical Exercises (see references) and direct observations to assess new skills taught in the trainings (e.g., communication, working with interpreters). These approaches require greater resources, such as access to standardized patients, that may not always be widely available.

Comprehensive Program Evaluation

In some settings it may be desirable and feasible to do more comprehensive and robust program evaluations. In addition to self-assessment by participants, trainers may want to consider capturing the following types of information:

- **Description of participants**
  From the institutional perspective it is often useful to know about the participants who attended the training, if attendance was mandatory or voluntary and if the attendees had prior cultural competency training. It is also helpful to describe the characteristics of the participants regarding their clinical background, and their prior experience.

- **Qualitative data**
  Open-ended questions often help to identify substantive information about what participants found most useful in the training and what changes they anticipate making in their daily practice.

  Focus groups, conducted at the conclusion of the formal training, can often elicit information from trainees that might not be easily gathered in a written evaluation or survey.

- **Program development and implementation**
  A description of trainers, planning, and program content along with information about the costs of training is often useful when soliciting institutional support.

  A description of the institutional environment along with the local social and political circumstances that influenced program development and implementation can be helpful in securing on-going funding support for cultural competency training programs.

- **Effect on patient care**
  At the institutional level, patient satisfaction reports before and after the training can be critical to garnering commitment for cultural competency training at the leadership level. Moreover, patient health outcomes, comparing outcomes before and after training to demonstrate positive changes, are likely to be the most compelling data for demonstrating the efficacy of cultural competency training.

- **Lasting effects on participants**
  It is often useful to demonstrate the long-term impact of training on participants' self-reported knowledge, skills, behaviors. In this situation a survey conducted at a specific time interval after training can identify enduring effects of training and an extra "value-added" to the cost of the initial training program.

Examples of Evaluation Questions

Below are sample questions you may want to consider as you formulate your training evaluation. As a reminder, questions should be written in relation to your stated objectives.

1. Trainees' self-efficacy, the conviction that s/he can successfully execute a learned behavior, can be assessed using a Likert scale with the following choices: "not confident," "somewhat confident," "very confident," "not applicable." Possible questions are:

   "How confident are you in your ability to work effectively with interpreters when taking care of patients with limited English skills?"

   "How confident are you in your ability to elicit patients' beliefs about their illness?"

2. Changes in attitude can be assessed if the same questions have been asked in a pre-training questionnaire. Once the training is complete, you may be able to demonstrate change with the following questions that seek degrees of agreement or disagreement:

   "Cultural competency is an idealistic goal."

   "Being culturally competent is mostly an issue of being respectful of others."

3. Open-ended questions are useful in gathering information about the training that might not have been anticipated by the trainer.

   "In what ways was this workshop useful to you?"

   "In what ways could this workshop be improved?"

4. Questions pertaining to the work setting are useful in gathering information about how participants view institutional support. These questions are especially important if the cultural competency training has been sponsored and supported by the participant's organization. Such open-ended questions might include:

   "Describe the one factor that most enhances (or most limits) your ability to promote cultural competency in your work setting."

   "Do you feel that your organization is committed to promoting cultural competency?"

Evaluation data can be especially powerful if you are able to triangulate results of program evaluation surveys. For example, evaluation results can be combined with qualitative data from participants, patient satisfaction surveys, or information about use of health care services (e.g., use of a medical interpreter during an office visit) or other information that may be available in your organization.

Conclusion

Evaluation is too often viewed as a last minute requirement. In this context it can seem tedious to develop and results in findings that appear ambiguous or unclear. However, if the trainer is committed to cultural competency training and believes it is possible to improve the health care of diverse communities through education, it is his/her responsibility to demonstrate the efficacy of this work. We wish you good luck in your efforts!

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FOR THE HEALTH PROFESSIONS
University of California, San Francisco

3333 California Street • Suite 410
San Francisco, California 94118

Phone: (415) 476-8181
Fax: (415) 476-4113

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